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ABSTRACT

This publication presents the substance of a conference on collaborative approaches to prevention and intervention for African American families exposed to community violence. Participants included child and maternal mental health professionals and others involved in public health, juvenile justice, child welfare, education, child advocacy, and other federal programs. This report summarizes the key workshop presentations on the impact of community violence on African American children and families. The first section provides an overview of the scope of the problems. A summary report reviews the theoretical and conceptual frameworks that have guided research in this area. The third section focuses on the impact of community violence on the social and emotional development of African American children. An overview of prevention programs that have been developed to address violence is presented in the fourth section. The fifth section provides discussion of three violence prevention programs in Massachusetts, California, and Ohio. The sixth section addresses the lack of involvement from mental health professionals in the area of community violence. The final section presents three discussions of new directions that must be taken to more effectively address violence in the African American community. Appendixes contain a conference agenda, an 18-item annotated bibliography, a 4-item annotated resource list, and a participants list. (JB)

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THE IMPACT OF COMMUNITY VIOLENCE ON AFRICAN AMERICAN CHILDREN AND FAMILIES

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THE IMPACT OF COMMUNITY VIOLENCE ON AFRICAN AMERICAN CHILDREN AND FAMILIES

Collaborative Approaches to Prevention and Intervention

Workshop Summary

Mareasa R. Isaacs, Ph.D.

Funded by

Maternal and Child Health Bureau
Health Resources and Services Administration

and

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Substance Abuse and Mental Health Services Administration

of the

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The Children's Safety Network is a group of injury prevention centers sponsored by MCHB, fosters the development and inclusion of injury and violence prevention strategies into maternal and child health services, programs, and organizations.

The Child and Adolescent Service System Program (CASSP), a program of CMHS, assists states and communities to build systems of care for children and youth with or at risk of developing serious emotional disorders and their families.

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Foreword

An epidemic of violence has swept across our nation, affecting millions of African American children and adolescents daily. Many of these children die; others sustain lifelong disabilities. The level of emotional damage often goes unassessed and untreated. Living in a context of violence contributes to nihilism, to a sense of impending death and a "live for today" attitude that limits the futures of these children. It is not surprising that children whose lives are bounded by violence have trouble concentrating in school, see little reason to work hard, and experience high failure rates. Stress-related physical illness also may be a result of violence and victimization.

Historically, the major response to violence has been to enhance law enforcement. The time for violence prevention to become a major component of both health and mental health services, however, is past due. Violence is a health problem: it is a leading cause of death and disability. Violence is also a mental health problem: it leads to post traumatic stress disorder and other mental illnesses.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives (USDHHS 1991), the government document which identifies the Public Health Service objectives for improving the nation's health over the next decade, emphasizes the need to prevent the violence that is so drastically affecting the lives of children and adolescents. Objectives to address violence include reductions in the homicide rate, in weapon-related deaths, in assault injuries, in physical fighting among youth, and in weapon carrying by youth, as well as increases in conflict resolution education in schools and in comprehensive violence prevention programs. As a nation, we have made a commitment through the *Healthy People 2000: National Health Promotion and Disease*

Prevention Objectives to more systematically address the problem of violence.

To do so successfully will require a multidisciplinary and multi-agency approach. Public health agencies must work together with mental health agencies, and both must work with criminal justice, education, social services, and other agencies, as well as with coalitions of private groups.

In addition, we must learn to combine psychosocial, behavioral, health and educational approaches with legislative and technological strategies in order to change norms that regard violence as inevitable and impervious to prevention. We also must actively address the root causes of violence on our streets and in our homes. A problem of this magnitude requires the talents and hard work of a variety of individuals representing many fields and working together toward a common goal.

To begin to explore how various systems could develop common understandings of the problem and, specifically, to explore strategies for a more effective collaboration between mental health and maternal and child health agencies, the Child and Adolescent Service System Program (formerly part of the National Institute of Mental Health) and the Maternal and Child Health Bureau jointly sponsored a conference in June 1991 entitled "The Impact of Community Violence on African American Children and Families: Collaborative Approaches for Prevention and Intervention," which is summarized in this document. The conference brought together a diverse group of dedicated people, who were already concerned about the problem of violence as it affects African American youth, to further explore the underlying causes and the ramifications of violence, and to make recommendations for

action. It represented an important step in meeting the tremendous challenge before us.

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Acknowledgments

Many people assisted in developing the workshop on which this publication is based. Planning committee members who provided the conceptual framework and outlined the sessions critical to the workshop include: Marva Benjamin, CASSP Technical Assistance Center, Georgetown University Child Development Center; Hope M. Hill, Ph.D., Department of Psychology, Howard University; Carl J. Hampton, Psy.D., Progressive Life Center; Gerrie Maccannon, Office of Minority Health, Department of Health and Human Services; Maxwell C. Manning, Brooklyn Children and Family Services Network; John Richters, Ph.D., National Institute of Mental Health; Kenley R. Wade, Illinois Department of Mental Health and Mental Retardation; and Nancy Ware, Child and Youth Services, District of Columbia, Commission on Mental Health Services.

Anita Appel, Child and Youth Services Director, New York City Regional Office, New York State Office of Mental Health, was responsible for much of the organizational planning for the meeting. Laurie Duker, Children's Safety Network, National Center for Education in Maternal and Child Health, coordinated the development and publication of the proceedings. Robin Landis and Dan Halberstein, National Center for Education in Maternal and Child Health, designed the cover and interior of this publication, respectively, and Chris Rigaux acted as publications director.

The lead persons of the agencies co-sponsoring the workshop: Judith Katz-Leavy, Substance Abuse and Mental Health Services Administration (SAMHSA), and Jean Athey, Ph.D., Maternal and Child Health Bureau (MCHB), participated in planning and organizing the meeting and reviewing early drafts of the workshop summary. The meeting and the publication were jointly funded by MCHB and SAMHSA.

The workshop featured outstanding presenters. It is their work that made the workshop a success and forms the basis for this publication.

Mareasa R. Isaacs, Ph.D.
Workshop Coordinator

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Introduction

Increasingly, children in the United States are being exposed to and living in families and communities with high levels of violence. Community violence, in the form of homicides, has become the leading cause of death among African American males between the ages of 15 and 44 years. It is important to note that most homicide figures only include mortality rates from homicides. These figures do not include rates for violence that does not end in death but may result in permanent disability, hospitalization, emergency room visits, physician visits, or silent suffering. Further, there are large numbers of children who witness frequent violent behavior in their families and communities. Thus, the impact of violence in the African American community spreads far beyond the number of homicidal deaths.

From the published research, we know that children exposed to violent incidents often suffer from a range of physical, social, educational, and emotional problems. Although research in this area is sparse, initial studies suggest that African American children's exposure to community and/or family violence dramatically and negatively influences their ability to experience and modulate states of emotional arousal, their images of themselves, their beliefs about the likelihood of surviving into adulthood, their willingness and ability to form positive affective relationships, their sense of morality, their beliefs in a just and benevolent world, and other areas central and germane to normal/adaptive development.

Despite the impact of violence and exposure to violence on the physical and emotional health of many African American children and families, few child mental health programs or maternal and child health agencies highlight or address the issue in any significant way. To date, there have been few research studies, and scant attention has been paid to the development of effective pre-

vention and intervention services focused on African American populations.

Focus and Objectives of Workshop

As an attempt to increase awareness of the significant impact of community violence on the social and emotional development of African American children and families and to examine the role that mental health and maternal and child health agencies could play in the implementation of effective prevention and intervention strategies, a workshop was held at the Loew's Summit Hotel in New York City June 13–15, 1991. This invitational workshop, entitled "The Impact of Community Violence on African American Children and Families: Collaborative Approaches to Prevention and Intervention," was cosponsored by the Child and Adolescent Service System Program (CASSP), National Institute of Mental Health (NIMH), and the Child and Adolescent Primary Care Services Branch, Maternal and Child Health Bureau (MCHB).

Approximately 70 participants attended the meeting (see appendix D). These participants were primarily child mental health or maternal and child health professionals from states that were identified as having high rates of African American male violence. In addition, those involved in public health, juvenile justice, child welfare, education, child advocacy, and other federal programs were invited to attend.

The workshop had six major objectives:

1. To increase understanding and awareness of the extent, prevalence, and nature of community violence in African American communities and its impact on children and families;

2. To examine and explore various theories about the causes and consequences of increasing violence and death among African

American youth and ways that the cycle might be interrupted and reversed;

3. To describe and examine current efforts to prevent violence in African American communities from state, city, and/or grass-roots perspectives;

4. To identify the critical environmental, cultural, familial, and individual "protective" mechanisms that act as positive coping strategies to mitigate the deleterious impact of community violence on African American children and families;

5. To examine and clarify the roles that mental health and maternal and child health programs and professionals can play in preventing and treating African American children and families who live in high violence communities; and

6. To explore the development and effectiveness of collaborative efforts and community coalitions in addressing violence in the African American community.

The workshop agenda is included as appendix A.

The remainder of this report summarizes the key workshop presentations on the impact of community violence on African American children and families. The first section provides an overview of the scope of the problem, identifying the extent, prevalence, and nature of community violence in African American communities. Next, the summary report reviews the theoretical and conceptual frameworks that have guided research in the area of violence and its impact on children. The third section specifically addresses the impact of community violence on the social and emotional development of African American children.

An overview of prevention programs that have been developed to address violence is presented in the fourth section. This section

also addresses the issue of evaluation of violence prevention efforts. The fifth section provides a discussion of three violence prevention programs in the states of Massachusetts, California, and Ohio.

The next section addresses the lack of involvement from mental health professionals in the whole area of community violence. The presentation addresses some of the reasons for this and suggests that mental health professionals may have to develop a new treatment paradigm to meet the needs of African American children who are victims of community violence.

The seventh section of the summary presents three discussions of new directions that must be taken to more effectively address violence in the African American community. The major theme is that, in order to understand and intervene in African American violence, it has to be understood in the political and social context of African American communities. A set of recommendations to federal and state agencies completes the workshop summary.

The workshop summary was developed from oral presentations as well as papers developed by presenters for the workshop.

The Scope of the Problem

According to a recent report from the Centers for Disease Control (1990), in 1987, homicides accounted for 42 percent of deaths among young African American males. The homicide rate for this group was 84.7 per 100,000 as compared to 17.7 per 100,000 African American females, 11.0 per 100,000 white males, and 3.9 per 100,000 white females (*see* figure 1). This rate was also 40 percent higher than that reported in 1984. Firearm-associated homicides accounted for greater than 80 percent of the deaths among African American males and for 95 percent of the recent large increase in the homicide rates in this group (*see* figure 2). In some areas of the country, the homicide rate for African American males exceeds the casualty rate among soldiers in Vietnam (Colburn 1990). Nationally, one of every 1,000 young African American males is murdered each year. This means that a young African American male is six times more likely to be murdered than a young African American female, nine times more likely than a young white male, and 26 times more likely than a young white female (CDC 1990).

Lifetime risk of homicide varies dramatically by race, sex, and age group (*see* figure 3). Overall, the homicide rate for African American children is 6 times that for white children and is higher for all age groups regardless of gender. In no age group is this difference more staggering than in males ages 15–19. African American males ages 15–19 are almost 10 times more likely to be victims of homicide than their white male counterparts.

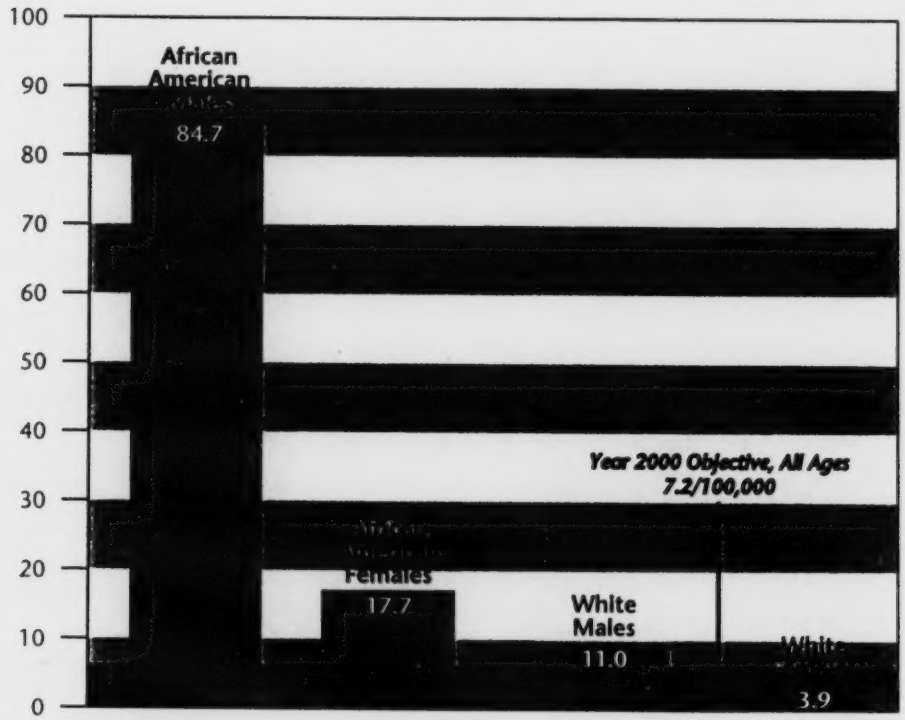
The CDC report (1990) identified four particularly disturbing aspects of the rising homicide rate in young African American men:

1. Gunshots caused more than 80 percent of the deaths and accounted for 96 percent of the recent increase;

2. The rise since 1984 was highest in adolescent African American males between the ages of 15 and 19 years;
3. The already large gap between the homicide rates of African American men and those of other groups is widening; and
4. Certain states have extraordinarily high rates.

In fact, homicide was found to be a significant contributing factor to the decline in life expectancy for African Americans in a recent report published by the National Center for Health Statistics (1990). Robert G. Froehike, a medical epidemiologist in the CDC's

Figure 1
Homicide Rates* for Persons 15–24 Years of Age, By Race and Sex
United States, 1987



* Per 100,000 Population

Source: Centers for Disease Control, Morbidity & Mortality Weekly Report, *December 7, 1990.*
Modified from Education Development Center, Inc., 1991.

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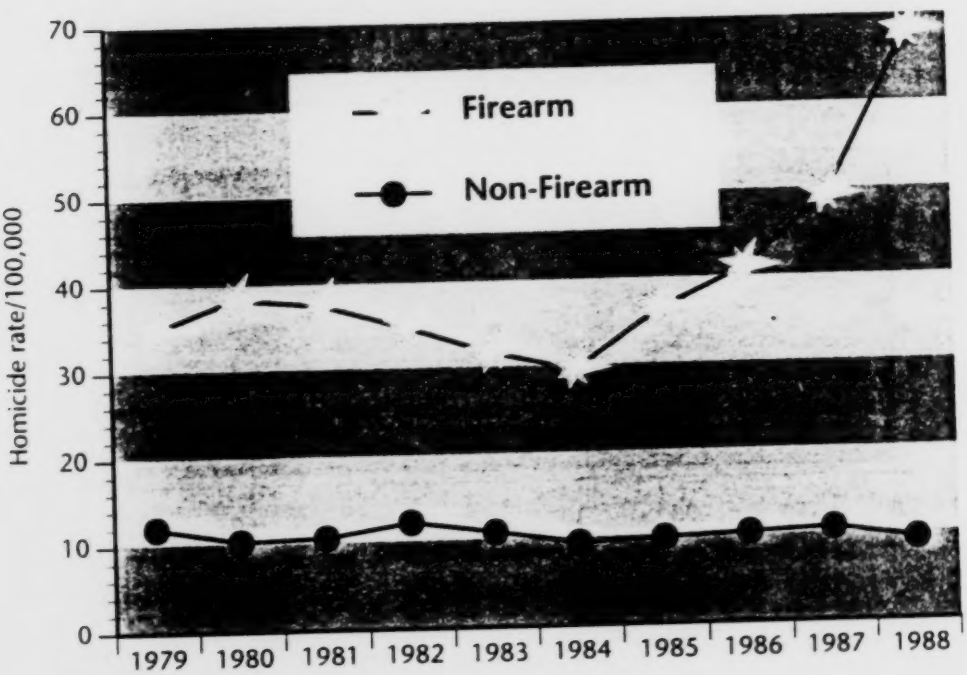
Division of Injury Control and the chief author of the CDC report, views this epidemic of violence as a major public health threat. He states (Colburn 1990): "If there were a disease responsible for over 40 percent of the deaths of a group of people that should be in peak physical health and it had increased by two-thirds in four years, and we knew there was an agent that accounted for 80 percent of those deaths (guns), there would be substantial public health efforts to address that" (p. 7).

The CDC study also noted that, of the 23 states with a population of young African American males sufficient to enable stable estimates, 14 had a homicide rate for this group that exceeded the 1990 U.S. health objective of less than 60 deaths per 100,000 (*see*

Figure 2
Firearm vs. Non-Firearm Homicide Rates*
African-American Males, 15–19 Years of Age, 1979–1988



* Per 100,000 Population

Source: Fingerhut, L., and National Center for Health Statistics (NCHS), unpublished data. Vital Statistics, Mortality Statistics for Ages 0–19

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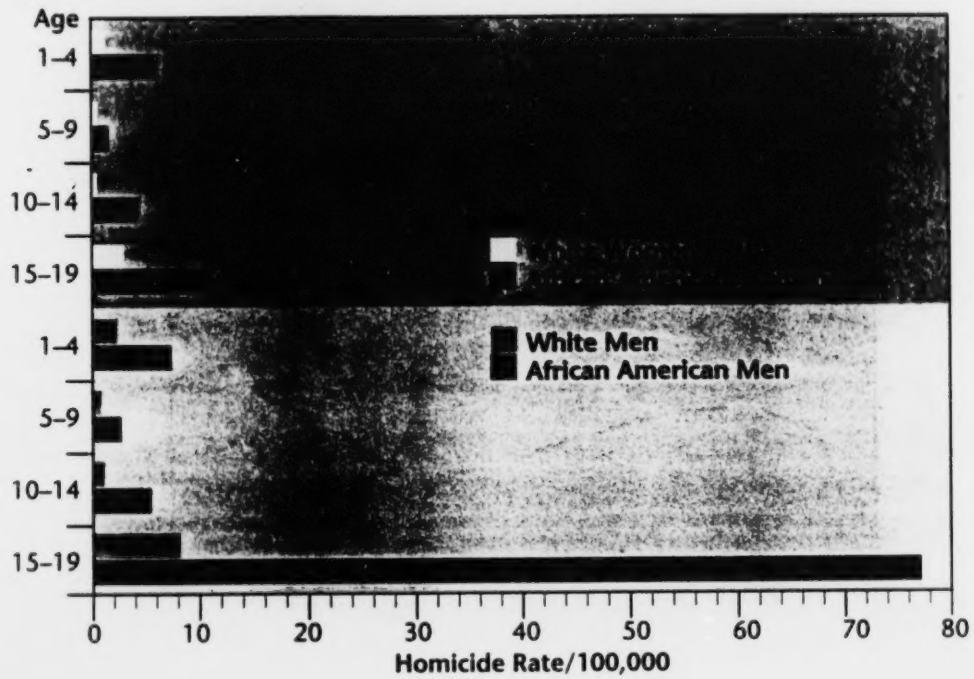
figure 4). Rates exceeded 100 per 100,000 in California, Florida, Michigan, Missouri, New York, and the District of Columbia. Factors identified as potentially important contributors to homicide include immediate access to firearms, alcohol and substance abuse, drug trafficking, poverty, racial discrimination, and cultural acceptance of violent behavior. The CDC report notes that "research and evaluation efforts have not yet demonstrated effective programmatic approaches to prevent homicide among young African American males" (p. 872).

Figure 3
Homicide Rates* by Race, Gender, and Age Group, 1988

Overall, 1 in 496 white women die by homicide; 1 in 205 white men die by homicide; 1 in 117 African American women die by homicide; and 1 in 27 African American men die by homicide.†



*** Per 100,000 Population**

Source: Fingerhut, L., and National Center for Health Statistics (NCHS), unpublished data. Vital Statistics, Mortality Statistics for Ages 0–19.

† Source: FBI Uniform Crime Reporting, 1989, unpublished data. As cited in *Centers for Disease Control, Draft Position Paper, Panel on Violence Prevention, February 14, 1991.*

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Although violence among African Americans has reached epidemic proportions, the problem has not been viewed as a critical public health or social issue in the minds of most Americans. When the problem does receive attention, the focus is more likely to center on the criminal justice system or police force rather than on prevention and public health. This approach is a reactive one rather than one that adequately addresses preventing and stemming the tide of violence within African American communities. There is very little research into the causes and consequences of

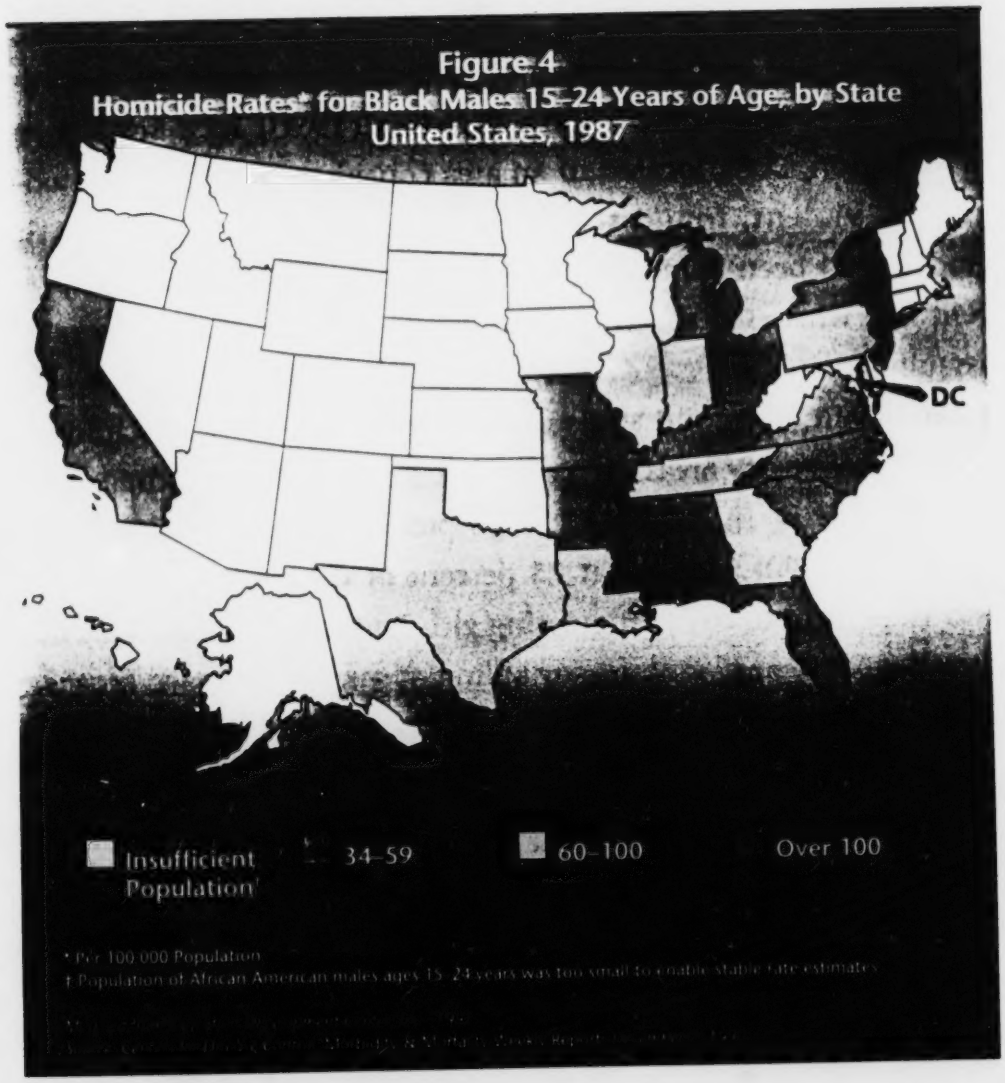
Figure 4
Homicide Rates* for Black Males 15–24 Years of Age, by State
United States, 1987
DC
Insufficient Population†
34–59
60–100
Over 100
* Per 100,000 Population
† Population of African American males ages 15–24 years was too small to enable stable rate estimates

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violence in African American communities and even fewer prevention and intervention programs focused on these issues.

The problem becomes even more complex when we realize that violence in African American communities affects not only the victims, but also the survivors. More and more young African American children and family members witness or are exposed to violent behavior in their daily lives. A recently completed study of fifth graders in a school located in an economically deprived area of New Orleans found that 40 percent of these 10-year-olds had seen a dead body, 72 percent had witnessed weapons being used, and 49 percent had observed a wounding (Osofsky 1990). A similar study conducted by John Richters (1990) in a school in Washington, D.C., located in an area considered to be only 'moderately' violent, found that 12 percent of the fifth and sixth graders had been shot, stabbed or sexually assaulted and 22 percent had witnessed someone else being shot, stabbed, or sexually assaulted.

Similar findings and statistics have been gathered for children in other inner-city areas. In a recent survey of 1,035 children, ages 10 to 19 years, in several Chicago public schools, Shakoor and Chalmers (1990) found that 75 percent of the participating boys and 10 percent of the participating girls had directly witnessed the shooting, stabbing, robbing, or killing of another person. Most of these children never receive any type of screening or mental health intervention to determine the impact of this violence on their social and emotional development. Certainly, the implications for the normal development and functioning of these children raise enormous issues for the African American community and the larger American society in general.

It is within this context that Beverly Coleman-Miller, M.D., special assistant to the Commissioner of Public Health and coordina-

tor of the Office of the Medical Examiner in the District of Columbia, addressed workshop participants. Speaking from experience, Coleman-Miller "personalized" the extent and nature of violence in the African American community. In her portrayal of the impact of this violence, Coleman-Miller made the following salient points and observations:

- Ninety percent of adolescent homicide victims in the District of Columbia are shot. Often these youth use highly sophisticated weapons such as automatic rifles, Uzis, and other semi-automatic firearms, in addition to the omnipresent handguns. These adolescents seem to have complete and immediate access to a range of lethal weapons. The fundamental question arises: how is the system set up so that adolescents can obtain guns and ammunition so easily? This is a central issue that deserves critical attention. Many of the deaths would be preventable if firearms were not so readily and easily available. Where do these firearms come from?
- One impact of such a high prevalence of violence is fatalism and a heightened acceptance of death within the population. Children and families who have experienced chronic violence lose, slowly but surely, their ability to be emotional. Affect and emotions become blunted. It is hard to imagine African American mothers with no tears for their own children; yet we have reached the point in the District of Columbia where mothers who have lost more than one child to violence are often quite unemotional at their children's funerals. Death from violence is an everyday occurrence in the lives of many of these families. It is not uncommon, for example, for adolescents in the District of Columbia to attend two or three funerals a week—funerals of friends and loved ones. Imagine what impression of

the world and the future one would be left with in a similar situation. It is not surprising that many of these children view themselves as "already dead and just waiting for it to happen."

- Many of the children who are frequent witnesses of violence, and many of those who kill, develop specific personality profiles very similar to those who have been heavily traumatized by the atrocities of war. There is an unconscious "secondary self" that divorces itself from the horror associated with killing another person. It is this ability that allows professional killers to appear to be removed from their actions, to go home and have dinner after murdering someone. This characteristic can be seen in some of the young perpetrators of violence in the African American community.
- Many children in these communities witness shootings and murders with some frequency. Often parents feel powerless to prevent these occurrences and are in a state of numbness themselves. Moreover, when parents are engaged in a basic struggle for survival, witnessing violence may not be considered a major ordeal. This reaction suggests a significant level of trauma and stress among the population that is not being sufficiently addressed by our service systems.

Coleman-Miller posed the question of what to do about violence by comparing the behavior of many of these youth to that of persons with terminal illnesses. In such situations, one often adopts a "live every moment to its fullest" attitude with little thought of the future. She suggested that if we viewed these young people as being terminally ill, then the interventions and solutions to combat violence would be very different.

Coleman-Miller noted that we, as a society, do know how to combat the impact of violence on children. While the war in the Persian Gulf was occurring, she observed that a number of televi-

sion shows were devoted to shielding children from the horror of war, allowing them to talk about their fears and anxieties in schools and other settings, and providing information to parents about how to approach the war with their children. Based on the premise that it is dangerous for children to witness violence, mental health and other professionals spent a considerable amount of time working with children and teachers in schoo! around the war in the Persian Gulf. Why are these resources and knowledge not utilized to mediate the exposure to violence by children in many African American communities who are intensely and consistently exposed to these dangers? Why has there not been the same concern for the health and safety of these children? If it is dangerous for children to witness a war that is carried on thousands of miles from where they live, then how much more dangerous is it for children to directly witness violence in their own homes and neighborhoods?

In summary, Coleman-Miller suggested that one promising model for violence prevention seems to be school-based interventions. She also strongly urged that adolescents themselves be included in all attempts to find solutions to the problems of violence. Not only are many of these adolescents quite articulate about their feelings and responses, but their participation provides another opportunity to make violence real—to match statistics with people. For action, violence must become real to professionals.

Finally, she suggested that graduate schools need to create a curriculum that emphasizes the skills needed for conflict resolution and violence prevention. There should be specialties in domestic violence and abuse leading to well-trained professionals able to address the different emotions and fears that violence often provokes. She suggested that violence in African American communities must be viewed as a critical public health problem—one that

requires a coordinated response from every aspect of the community, including mental health, public health, education, and criminal justice professionals. Then, and only then, will violence prevention and reduction receive the kind of attention and recognition that it needs and deserves.

Theoretical and Conceptual Frameworks

Malcolm Gordon, Ph.D., a psychologist in the Violence and Traumatic Stress Research Branch at the National Institute of Mental Health (NIMH), discussed the theoretical and conceptual frameworks that have dominated the research on violence. He acknowledged that there has been little research on violence afflicting some inner-city neighborhoods and the subsequent effects on the lives of children and families residing in such neighborhoods. Although not specific to African American youth, there is a large body of research that has examined the effects of violence and other types of traumatic events on adults and children.

Five major conceptual frameworks have emerged in an attempt to explain the types of effects caused by violence and traumatic events and the characteristics that lead to such effects. These frameworks are not necessarily competitive, but tend to focus on different and sometimes complementary aspects of the effects of violence on children and adults.

Victimization Experience/Symptomatology Framework

This conceptual framework describes the linkages between characteristics of the experience of violence and individual symptomatology and dysfunction. A more sophisticated form of this framework incorporates hypothesized mediating variables (cognitive, affective, social, or biological). One fundamental question for this research has been whether exposure to stressful or traumatic events has any lasting effects at all? Although it might seem obvious that it does, there may be other explanations for symptoms of distress.

Recent research has conclusively demonstrated the direct effects of exposure to violence and other traumatic events on symptomatology; these effects vary with the degree of exposure. For example, studies have shown that children exposed to war or other

types of violence have more serious and persistent symptoms corresponding to their proximity to the violence and the extent of direct exposure.

Researchers also have found that there is a commonality in the types of symptoms experienced by children exposed to a wide range of traumatic events. They may be classified as follows:

- Somatic or physiological reactions, including sleep disturbances, hyperarousal symptoms, and regressions in bodily functions;
- Emotional symptoms, including arousal symptoms like anxiety, fearfulness, and anger, and dampening symptoms like depression and guilt;
- Behavior problems, including increased aggression, withdrawal, repetitive re-enactment and self-destructive behaviors, and school problems;
- Cognitive disturbances, including worrying, obsessing, obtrusive thoughts and dreams, and problems concentrating; and
- Possible alterations in personality organization.

Stress and Coping Framework

This theoretical framework draws on developments in the stress and coping literature and applies them to the experience of violence, with violence defined as a stressful event. It attempts to explain individual variability in the effects of events as being due to the characteristics and intensity of stress, the coping response of the individual, and individual differences in vulnerability or ability to recover from stressful events (resilience or protective factors).

The intensity of the stressful events, the ensuing psychic disequilibrium, and the success of the individual's coping efforts determine the impact of stressful events on the individual's function-

ing. These relationships are additionally affected by two other constructs: (a) "vulnerability," which refers to characteristics of the individual that lead to larger amounts of psychic disequilibrium from stressful events or to utilization of less successful coping strategies; and (b) "resilience" or "protective factors," which refer to individual or situational characteristics that ameliorate the relationship between stress, distress, and functioning.

Some results from the research on the effects of stress arising from exposure to violence suggest that:

- Dreams, drawings, and behavioral symptoms are often a better indication of the amount of strain experienced by children exposed to violence than are the child's self-report or the parent's report.
- An important vulnerability factor is exposure to previous stressful events. Two possible outcomes of repeated exposure are: (1) sensitization to events leading to exaggerated responses, or (2) habituation leading to decreased responses.
- Four protective factors that continually emerge in studies of children are: (1) Personal resources, such as intelligence, social skills, and coping strengths; (2) social support from family and peers; (3) role models available who exhibit positive coping behaviors, and (4) community values and beliefs (e.g., ideology for a nation at war or in a nationalistic struggle or religious beliefs).
- More effective coping strategies engaged in by children exposed to war or community violence include talking with people, thinking positively or optimistically about events, reframing the meaning of events, using humor, distracting oneself, and seeking information.

Traumatic Response Framework

This framework attempts to explain the effects of intensely aversive events which seem to overcome the coping capacities of most individuals. The framework draws especially on studies of post traumatic stress disorder (PTSD) in traumatized groups, such as combat veterans and rape victims. PTSD is classified as an anxiety disorder and its symptoms are generally considered to be of three broad types: (1) re-experiencing symptoms (e.g., flashbacks and dreams of the traumatic event); (2) avoidance of fear eliciting stimuli associated with the traumatic event; and (3) increased physiological arousal states associated with specific stimuli related to the traumatic event or stimulation in general. Initially the study of PTSD focused on combat veterans, but it has been extended to include crime victims.

Children may experience PTSD, as shown in studies of children who have been victims of physical and sexual abuse or of war and community violence. For example, recent research has reported rates of PTSD in up to 50 percent of Cambodian adolescents exposed to traumas in childhood occurring during the Pol Pot regime, in up to 50 percent of children exposed to a playground sniper attack, and from 10 percent to 50 percent of sexually abused children.

Developmental Framework

This conceptual model attempts to explain both the short-term and long-term effects of stressful or traumatic events on children in terms of the developmental characteristics, capacities, or psychosocial stages of children and the impact on functioning at later developmental stages of earlier traumatic events. There actually has been very little research that focuses on developmental differences in response to and effects of exposure to violence and other traumatic events. Often the age of the child is used as a proxy for developmental stage because it is difficult to deal with the com-

plexities of defining and assessing individual differences in children's developmental trajectories.

Some results from developmental studies of the effects of violence on children are:

- Studies of children's responses to violence at different ages seem to indicate that the effects on children reflect a conflict between cognitive sophistication (i.e., understanding the meaning of the event and the extent of personal threat) and resources for controlling emotional reactions.
- Studies have indicated that disturbance in younger children is heavily influenced by the parents' reaction to the traumatic event. This becomes less true of older children and is not generally true of adolescents.
- Children's reactions to traumatic events are distinctly different at different ages. For example, preschool children who witnessed a parental murder were obsessed with details of the actual events; school-age children displayed a disorganized reaction that permeated many different areas of their functioning, such as schoolwork, peer relations, impulse control, and sleep disturbances; and adolescents who were not able to cope with the trauma developed adult-like PTSD symptoms.
- Studies have indicated important gender differences at different ages in the reaction to and ability to cope with the effects of traumatic events.

Ecological Framework

This framework attempts to expand the understanding of the effects of stressful or traumatic events by situating events and their impact within increasingly higher order social contexts ranging from the individual level to the parent-child relationship, the fam-

ily system, the community, and the cultural contexts. The experience of the individual takes place in and is influenced by these larger social contexts.

Studies of the social ecological context of individual experience are relevant to the study of the impact of community violence on children. Thus, one of the findings of studies of inner-city violence linking individual experience to family context is that children who live in violent neighborhoods are also exposed to much more violence within their families than are other children. Similarly, research has indicated that although violence and social dysfunction are strongly related to such socioeconomic indicators as family income, education, and employment, neighborhoods with similar socioeconomic profiles can differ significantly in neighborhood-based social support resources, perception of neighborhood quality, and tolerance for social deviance. One of the most important effects of community violence may be the disintegration of social support and community cohesion in high-crime neighborhoods as individuals with the most resources tend to leave these neighborhoods.

After presenting these frameworks and the associated research, Gordon addressed future directions. He stated that further empirical research and conceptual thinking are needed to clarify both the important constructs and their interrelationships in these various theoretical approaches. Additionally, he stressed that it is important to begin integrating these various approaches into a more comprehensive framework in which to understand the impact of community violence on children.

Social and Emotional Development

Hope Hill, Ph.D., a professor in the Department of Psychology at Howard University, Washington, D.C., discussed how community violence affects critical aspects of development of urban African American youth. Hill's presentation included a discussion of clinical impressions that she and her colleagues have observed of children in school, mental health, and community settings who have been affected by community violence. She also presented a conceptual model that she is currently developing at Howard University and described the Howard University Violence Prevention Project, a research effort designed to investigate the impact of community violence on children and to develop appropriate preventive interventions.

The focus of Hill's presentation was the population of children and youth who do not come to the attention of the public, but instead are the more silent victims. These are the children who are victimized by the presence of violence in their communities. Hill described these children as those who have to negotiate violence when they step out of their homes in the morning or when they come home from school in the afternoon. These are the children who know people who have been shot and killed; these are the children who in fact have witnessed the shootings; these are the children whose parents have to move their beds on Saturday night to protect them from the bullets whizzing past their windows. Hill has adopted the term "co-victims" of violence to describe these children in a more generic sense. She noted, however, that children exist on a continuum from co-victims to actual perpetrators of violence and that the lines of difference are almost nonexistent. The youngster who has lived amidst community violence and seen it modeled repeatedly may well be a co-victim one day and a perpetrator the next.

Hill explained that one of the goals at Howard University is to develop an appropriate conceptual framework from which to understand the impact of violence on the development of children. So far, there appear to be two models that hold the most promise. The first is an ecological model advanced by Urie Bronfenbrenner which accounts for the impact of various forces in the environment on the child's development. The second framework is the resilience/stress resistant model advanced by Garmezy and Rutter to understand the development of children who were able to overcome enormous stresses and move on to achieve competence in various aspects of their lives.

Hill described the following areas of analysis as central to an ecological model for understanding the impact of community violence on African American children and youth:

- The history of violence in America, including the impact of violence on African Americans during slavery;
- The social context, which has been influenced by history, social policies, and economic realities which have compromised the quality of life for many of these children; and
- The cultural context, which provides the blueprint for living and shapes norms, values, and belief systems.

The resiliency model for researching urban violence and African American children is needed to counterbalance the overabundance of research on the dysfunctional development of African American children with minimum research on normal development of these children. The interest in community violence could turn into another opportunity to "blame the victim" unless there is insistence that research be grounded in the social and cultural

context, focused on searching for resilience as opposed to simply identifying deficit functioning.

In the resilience paradigm, community violence can be considered a pervasive stressor imposed on an already vulnerable population of children and families. The salient questions become: (1) What are the events, experiences, and family process and individual factors which have served in the past and in the present to protect the development of children from being adversely affected by the stressor? and (2) How can we build upon these factors in developing effective programs? At present, Hill stressed, we do not know what is protective in the experience of children chronically exposed to urban violence because there is no empirically based research in this area. Therefore, her remarks in this area concerned only "potential protective factors" which demand further study and research.

In her own clinical research, Hill recognizes that there are multiple risks in the environments of children who live among chronic urban violence. The presence of violence is just one of a number of risk factors in these communities along with poor schools, inadequate social services, and high parental unemployment. Therefore, it is often difficult to isolate what the impact of exposure to violence is apart from the many other risk factors. She identified the following five major areas, however, that appear to be affected by the exposure to community violence.

Erosion of the Sense of Personal Safety and Security

A child's ability to acquire a sense of trust in himself or herself and in the outside world is dependent on the extent to which critical early relationships have created an environment of predictability, safety, and security. In an effort to begin to understand children's perceptions of community violence, Hill and her associ-

ates asked the children in her Washington-based research study to draw a picture of their neighborhoods, without suggesting to the children that the researchers were interested in violence. The majority of children from high violence areas drew pictures of drug-related violence in the neighborhood, including shootings, stabbings, and episodes which involved the police. Their stories about these pictures reflected concern about their personal safety and security in the community and at school.

Disruption of Lifestyle and the Major Agents of Socialization

The escalation of urban violence has significantly affected traditional sources of socialization and traditional havens of safety and security such as the home, the school, day care centers, and churches. Parents repeatedly report that they feel unsafe, not only in their neighborhoods, but in their apartment buildings and homes. Further, schools, often thought of as safe havens for children, have been the location for a number of violent incidents in the District of Columbia and elsewhere. As a result, critical buffers of environmental stress—the home and the school—have become increasingly challenged in their ability to protect and continue critical developmental experiences for the child.

Generalized Emotional Distress

Children's emotional reactions to witnessing community violence or living among constant and unpredictable violence may include fear, anger, hostility, confusion, anxiety, and hypervigilence. The Howard University researchers have observed children whose ability to concentrate in school and to take advantage of the academic program has been severely compromised due to their preoccupation with incidents of violence which have occurred in their community. Many of the teachers interviewed have indicat-

ed that they simply have to allow time to debrief children on these experiences before they can continue with the academic program.

Depersonalization

Increased exposure to unpredictable incidents of violence over a period of time can result in depersonalization during which the child emotionally distances himself or herself from the feared object. The researchers note that the defense of depersonalization becomes gradually strengthened with each subsequent incident. Many adolescents are able to so depersonalize some other persons that they become objects; the more one objectifies another, the easier it is to commit a violent act against that person.

Diminished Future Orientation

In her research, Hill noted that many of the younger elementary school children voiced age-appropriate plans and hopes for the future. As children grow into preadolescence, however, they see or know more and more children and adolescents who have been victims of homicide. As noted earlier in Coleman-Miller's remarks, many adolescents attend four or more funerals a month for their peers killed in street violence—experiences that would certainly diminish expectations for the future. Not surprisingly, researchers have found that many male adolescents do not expect to reach 25 to 30 years of age.

Any analysis of the impact of exposure to urban violence would be incomplete without discussing protective mechanisms, Hill contended. She noted that a great many children experience chronic violence on a daily basis and are still able to triumph over these enormous stressors and grow to be healthy social and emotional individuals. Possible protective mechanisms which the

researchers have observed and seen in the lives of children exposed to community violence include the following: (1) early bonded primary relationships which promote social development; (2) an adult who can buffer community violence; (3) experiences which promote affective development; (4) promotion of cultural awareness and positive cultural identity; and (5) an explicit value system that eschews violence. Parents and communities that have been able to promote an active understanding and appreciation of African American culture and a positive cultural identity have been able to instill a sense of self-protection and value in their children. Promoting a clear set of values in children seems to mitigate against their involvement in community violence.

These protective mechanisms, Hill suggested, can be programmed into preventive interventions with children exposed to violence in the following ways:

- Promoting the understanding of culture and the fostering of a positive sense of cultural identity. Culture may well serve as a protective mechanism by strengthening identity development, providing an ethos, creating a sense of belonging, and expanding a child's world view.

- Developing a specific value system which guides self-development, social relationships, conduct, and sense of self-worth.

- Providing opportunities for children and families to receive debriefing and supportive treatment after situations of community violence so that they begin to work through frightening feelings rather than simply repressing the experience.

- Building on spiritual values. This helps children to connect with a higher being and develop a sense of their place in the universe.

Hill and her colleagues have developed a research-based after-school group intervention for children who have witnessed instances of urban violence such as homicide, physical assaults, stabbings, nonfatal shootings, and/or the loss of a loved one to homicide. These children were selected because they are considered to be at high risk for later psychological distress and for possible involvement in violence. The intervention is conducted through psychosocial groups which are designed to provide support and reduce the psychological risk factors.

The intervention reaches out to both the parents and teachers of these children. A support network for the parents of the children in the group meets once a month. The purpose of this network is to empower parents to be more effective buffers for their children and to support their working toward transformation of the community. The parenting group provides specific strategies to promote the social and psychological development of their children despite living in a violent environment. The focus is on helping parents transform their communities and empowering them as opposed to simply helping them to cope or adjust to a maladaptive environment.

In conclusion, Hill stated that our mission can never be strictly focused on the individual or simply developing mental health interventions for children affected by violence. She suggested that we apply a public health model to the problem and view violence as a pathogenic element in our communities that is killing large numbers of our youth and psychologically damaging even larger numbers. We need to bring our power and research to bear at the federal and state levels to influence the issue of the impact of urban violence on child development in a significant way. We also need to build linkages between mental health and other agencies such as schools, law enforcement agencies, child care centers,

churches, and hospitals to develop comprehensive community programs to stem community violence. We must work at multiple levels, with the systemic level being the primary focus of attention. Our primary goal should be to reduce violence; secondly, to prevent youth involvement in violence; thirdly, to prevent the negative psychological consequences of children exposed to violence; and lastly, to develop culturally and socially appropriate mental health interventions for children who have been traumatized by community violence.

Prevention Programs

As in most public health models, prevention is considered the best line of offense in violence reduction. Therefore, particular attention was focused on prevention efforts and programs that are attempting to intervene and prevent violent occurrences in African American communities or among African American youth.

To provide an overview of prevention efforts and their effectiveness, Renee Wilson-Brewer, project director at the Education Development Center, Inc., in Newton, Massachusetts, described her activities in identifying and evaluating violence prevention strategies being implemented in communities throughout the United States. She described two recent reviews and discussed the effectiveness of these current efforts. She also cited several critical issues that have not been fully examined.

Starting with the review of violence prevention activities that she conducted for the Carnegie Corporation of New York in 1990, Wilson-Brewer presented the findings from a survey of violence prevention programs. Eighty-three programs were identified, and surveys were completed for 51 programs. The findings from this survey were:

- Almost all the programs surveyed collected some kind of data; however, these data typically included numbers of people served, number of persons trained, number of curricula sold, etc. It was impossible to determine with any certainty which programs were effective in preventing or reducing violence because few programs looked at outcomes or conducted follow-up with youth after their participation in the program had ended.

- The major barriers identified that affected the ability to make the program work successfully were: (1) securing adequate

funding; (2) working effectively with school systems; (3) developing community support to conduct gang prevention and intervention programs; and (4) conducting evaluations.

- For almost all programs, stable, long-term funding is nonexistent. This translates into an inability to hire needed staff, operate programs of significant scale and duration, or provide continuity of services. Inability to follow youth to determine if an intervention really does make a difference was a frustration expressed by many programs.

- Many prevention programs are school-based programs. Approximately half of all respondents working in school systems cited teacher stress and burnout as major barriers to their work. They stated that teachers, many with already heavy workloads, are often told they must implement a violence prevention program but have not been involved in the decision about how and when to do so. Many in the sample said that lack of uniform program application throughout the educational system was a barrier. This means that a program is often used in only one or a few classrooms within a school with little or no commitment from the school system to institutionalize violence prevention.

- Even in those schools that did want to implement programs, funds often were not available to purchase curricula, videotapes, and teacher training kits. In addition, school support services to deal with the severity of some students' problems often were lacking.

- Staff members of gang prevention and intervention programs cited many of the same barriers to effective functioning; however, at least half of them cited systemic denial of the existence of a gang problem as the major barrier to making their programs

work. This denial comes not only from city government but community residents, school systems, and parents. Other barriers included the increasing drug problem, increased levels of turf warfare, and the return from incarceration of older "hard core" gang members.

- Evaluation was a big issue for all these programs. A lack of understanding of basic evaluation procedures often was cited. Those who wished to conduct evaluations did not know how to find people with expertise in the field of evaluation who could provide technical assistance. Also, most had no or limited funds to devote to evaluation.

The complete findings and recommendations from this study have been published by the Carnegie Council on Adolescent Development of the Carnegie Foundation in New York.

Next, Wilson-Brewer described the review that the Education Development Center conducted for the conference entitled "Forum on Youth Violence in Minority Communities: Setting the Agenda for Prevention," cosponsored by the Centers for Disease Control, Minority Health Professions Foundation, and Morehouse School of Medicine. The conference was designed to summarize what is known about violence prevention so that information can be applied in minority communities and to determine priorities for the evaluation of violence prevention programs so that future research can be appropriately targeted.

Given the difficulties in evaluating the effectiveness of programs, Wilson-Brewer examined the range of strategies and interventions designed to prevent violence in the general population of minority youth, at-risk minority youth, and young children, and to control weapon use among minority youth. She also identified the principles of community-based programs and of evaluation.

Wilson-Brewer identified and classified the following types of strategies and interventions currently employed to address violence prevention: Educational, recreational, environmental/technological, and legal. There may be additional categories for some subgroups. The approach and emphasis for different groups may also be different within each of the general categories.

Educational Interventions

These interventions are designed to prevent violence by changing young people's knowledge, attitudes, and behavior patterns. The educational interventions for minority youth are of three types: (1) interventions to build male self-esteem (including manhood development curricula, mentors and role models, and immersion schools); (2) conflict resolution and mediation education (such as curricula, training, technical assistance, handgun violence education, and life skills training); and (3) public education interventions, including public service announcements, educational videotapes, and media education. Educational interventions appear to be somewhat successful and are the most common approach to violence prevention.

Recreational Interventions

These interventions are based on the concept that sports and physical activity provide an excellent outlet for pent-up tension, stress, and anger. Although recreational activities have not been viewed as a major intervention for the prevention of violence, well-designed multicomponent programs that include recreational interventions appear promising. Wilson-Brewer noted that there are many of these programs across the country, including those operated by the Police Athletic League, Boys and Girls Clubs, Girl Scouts, and YWCAs.

Environmental/Technological Interventions

These approaches have been very successful in addressing many public health issues because they are not dependent upon human behavior. Examples include child-proof safety caps and automatic seatbelts. The environmental and technological interventions that have been used to address violence prevention include metal detectors, concrete barriers, and several school-based strategies such as identification cards, closed circuit television, and "safe corridor" programs. Most of these interventions have not proven effective in reducing youth violence, although Wilson-Brewer emphasized that they are not widely implemented so their potential remains untested.

Legal Interventions

These include activities such as establishing youth curfews and policing school campuses. Many of these interventions, however, have been challenged as violations of the rights of young people. Limited data are available on the effectiveness of curfews or other such restrictions on youth movement to curtail violence.

For at-risk youth such as gang members and potential gang members, work/academic interventions were found to be promising. For young children, Wilson-Brewer found that the most effective primary prevention efforts are those that promote healthy parent-child interactions; prevent children from becoming victims and/or witnesses of violence; promote community-based, culturally relevant support systems involving parents, children, and the community; and target well children to build resiliency and develop social competence and problem-solving skills.

Wilson-Brewer and her colleagues found that, for those children who have already been affected by violence, opportunities for early intervention are greatly diminished. Therefore, interventions

are needed to address the child's mastery of interpersonal, decision-making, impulse control, and communication skills; the teacher's delivery of sequenced, age-appropriate messages about violence within the context of a comprehensive, integrated health curriculum; the parent's continued involvement in the child's development; and the community's support and responsiveness to the challenges facing today's families.

Wilson-Brewer made the following general observations about violence prevention programs.

- Many of the violence prevention interventions currently being employed do not have as their sole target minority youth; they are designed for youth in general. When they are targeted on minority youth, however, the minority group targeted is almost always African American youth. There are very few programs designed to address the specific needs of Hispanic, Native American, or Asian American youngsters and communities.

- Most of the violence prevention programs for the general population of minority youth are school-based programs, perhaps because schools provide the largest "captive" audience.

- Some programs have been developed with a specific focus on violence, with a concentration on education regarding risk, conflict resolution and mediation. Others take a holistic approach and address a cycle of interacting problems through life skills training, mentoring, Afrocentric education, academic tutoring, substance abuse prevention education, and career development courses.

In conclusion, Wilson-Brewer outlined some of the critical issues facing the evaluation of violence programs. She noted the following issues as most important:

- Distinguishing between race/ethnicity and socioeconomic status when planning violence prevention efforts. There is some research that suggests an association between socioeconomic status and high rates of interpersonal violence might be stronger than the association between race/ethnicity and violence.
- The need for additional quantitative data. Currently, most data focus on violence that results in homicide. There is much violence or exposure to violence, however, that does not result in homicide but that may cause serious injuries or disabilities and/or long-lasting psychological damage. Information about these aspects of violence is not captured by current data sources on violence.
- Additional research and data are needed on homicide and violence among other peoples of color. For example, limited data exist on violence among Hispanics, although for Mexican Americans it is the second leading cause of death among adolescents and young people. Also, little attention has been paid to the high level of violence and homicide among certain Native American population groups. There is a need for programs that focus on other racial and ethnic minorities as well as more programs focused specifically on African American males.
- Most attention, due to numbers, has been placed on African American males. There has been little theory, research, or practice focused on minority females although

African American females are overrepresented in the criminal justice system (they constitute approximately 74 percent of the female arrests for murder). The rate of homicide for African American females is also high and is increasing. There are no violence prevention programs solely for minority females, yet this clearly is a growing concern.

- The current trend toward Afrocentric education as well as the teaching of African American male students by African American teachers, primarily male, should be closely examined. If such efforts are successful in increasing the self-esteem and academic performance of African American students, they will have a positive effect on violence prevention. Even if this intervention strategy proves effective, however, it cannot be used with other racial and ethnic minority students unless there is an increase in the number of minority teachers.
- Effective violence prevention requires a multidisciplinary approach. It requires public health professionals, educators, mental health specialists, medical personnel, child advocates, lawyers, and criminal justice and law enforcement staff. It is not a problem that can be solved by only one discipline. It also requires collaboration with communities and families that have too often been left out of current strategies and efforts.

Building on Experience

Leaders of violence prevention program models in three different states—Massachusetts, California, and Ohio—described their programs and discussed some of the lessons they have learned from working to prevent or reduce violence in African American communities. The three violence prevention programs illustrate the different approaches that might be taken in developing effective programs—working with communities and schools, involving relevant community agencies and leaders, as well as the adolescents themselves, and focusing on some of the underlying causes and risk factors associated with violence. All three programs emphasized collaborative approaches between community agencies and government agencies. They also tailored violence prevention efforts to fit the culture of the target population and community, a critical element for effective programs. Finally, all three programs highlighted the importance of skilled and committed leadership in violence prevention activities.

The Massachusetts Adolescent Violence Prevention Project

Paul Bracy, coordinator of the Adolescent Violence Prevention Project in Massachusetts, began his presentation by discussing some of the background information that was used to conceptualize the project. The project developed out of an increasing concern about the rising number of homicides in several Boston communities. The annual number of homicides in Boston rose from 95 in 1988 to 148 in 1990. African Americans were overwhelmingly the victims and perpetrators of homicide in the Boston communities. Violence became the leading cause of death for Boston's African American males and females ages 15–19 years.

The data present a profile of the typical homicide victim in Massachusetts: He was male, killed by someone he knew, and usu-

ally of the same racial group as the perpetrator. He was most likely to have been killed with a handgun, following an argument, after alcohol and/or other drugs had been used.

Other factors that seemed to increase the risk of violence included: racism, sexism, poverty, youth gangs, domestic violence, access to firearms, inadequate parenting, violent entertainment, child abuse and neglect, and the use of alcohol or other drugs.

In 1990, the Massachusetts Adolescent Violence Prevention Project received funding for five years from the federal Maternal and Child Health Bureau (MCHB) and the Massachusetts Department of Public Health (MDPH). The overall goal of the project is to strengthen the capacity of communities to prevent adolescent interpersonal violence. The project takes a community-based approach which recognizes that the magnitude and complexity of the problem require community collaboration and community involvement. Two communities—Boston and Lawrence—were chosen as the sites for the project. The objective of the violence prevention project is to have each community: (1) form a community-based coalition; (2) develop interventions and funding plans; and (3) implement and evaluate the interventions.

The project will be implemented in each community through four phases of operation.

- *Coalition Development:* This involves enlisting key community leaders and providing training on issues of community development, collaboration, empowerment, violence prevention, and cultural sensitivity. Each coalition will develop and implement a needs assessment process.

- *Planning:* Based on the needs assessment and known effective models, an implementation plan with specific interventions and their evaluations will be developed. Securing funds for

implementation will be the responsibility of the coalition with assistance from the MDPH.

- *Implementation of Interventions:* These may include educational, technological, legislative, and/or regulatory strategies. The MDPH staff will assist coalitions in selecting interventions with demonstrated effectiveness.
- *Dissemination and Replication:* All aspects of the project will be described in a manual to be disseminated among state MCH directors, injury prevention programs, and other relevant organizations.

At this time, each of the community projects has identified a lead agency and hired a director to build the coalition and prepare the implementation plans. The prevention projects will address many levels of interpersonal violence, including homicide, assault, child abuse, child sexual assault, spousal violence, sexual assault, peer violence, and elder abuse. In addition, the MDHP will make the following resources available to the two communities:

1. Access to large numbers of adolescents through funded programs;
2. Access to health-related data;
3. Access to health care providers;
4. Knowledge and history of unintentional injury prevention programs;
5. Linkages with substance abuse, sexual assault, domestic violence, and surveillance programs; and
6. Specialized technical assistance and consultation on an as-needed basis.

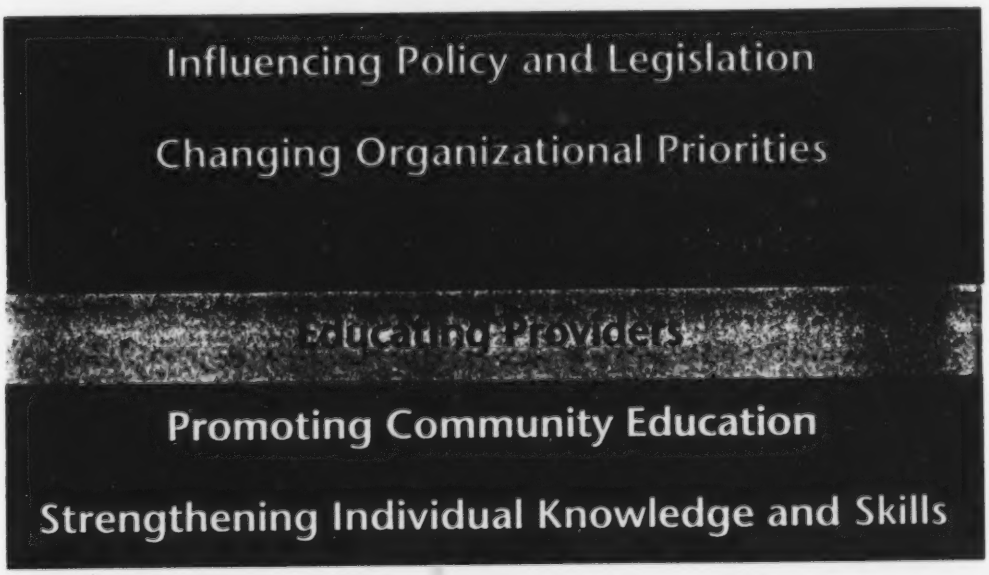
Bracy concluded by discussing the evaluation component of the project. This will consist of monitoring the development of the

community coalitions and assessing the impact of interventions on injury incidence rates. Thus, the evaluation will include both process and outcome measures. The overall impact will be determined by the degree to which the objectives and changes in the health system problems have been achieved.

Contra Costa County Prevention Program

Larry Cohen, director of the Prevention Program at the Contra Costa County Health Services Department, discussed the violence prevention efforts being undertaken in his county. He stated that since so many systems come to bear in violence prevention a systematic response is needed. His prevention program utilizes a tool called the Spectrum of Prevention (*see* figure 5). This tool outlines a variety of activities that can have an impact on prevention, such as influencing policy and legislation; changing organizational practices; fostering coalitions and networks; promoting community education; and strengthening individual knowledge and skills. To date,

Figure 5
The Spectrum of Prevention



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the county has placed greatest emphasis on getting many diverse people and organizations to work together for violence prevention. Through funding from the federal Maternal and Child Health Bureau (MCHB) and Office of Minority Health (OMH), the county has developed a violence prevention demonstration project in the community of Richmond, California.

This demonstration project builds upon an existing county coalition of agencies—Alternatives to Violence and Abuse Coalition (AVAC)—in conjunction with the government, the school district, the city of Richmond, and the Contra Costa County Board of Supervisors district representatives. In addition, Opportunity West, which represents many of the grass-roots organizations in the Richmond area, has joined the coalition. All of these groups were brought together into a PACT, an acronym for Policy, Action, Collaboration, and Training.

Some of the activities of the Violence Prevention Project include: (1) supporting youth and community leadership; (2) embedding violence prevention in community institutions so that the efforts will continue after the grant ends; (3) teaching specific skills to reduce fighting and date rape; and (4) identifying and utilizing effective violence prevention activities.

An important concept underlying the Richmond violence prevention program is that oppression must be identified as a key component of violence. Young people are learning to be violent for a reason. The program teaches that there are options and alternatives to violence. These options depend on community involvement, social and cultural activities, public policies, educational alternatives, and economic opportunities. An example of an educational alternative is the promotion of effective in-school suspension programs in order to prevent sending kids out into the streets. To increase economic opportunities, the program uses

funds to hire young people themselves to assist in initiatives such as a Rap Contest on preventing violence.

Through these and other violence prevention efforts, Cohen's program has arrived at a number of conclusions that are important in developing effective violence prevention programs:

- The economic situation within a community is absolutely critical. Poverty, unemployment, and underemployment lead to significantly increased levels of violence.
- Government's responsibility is not to always set up new, stand-alone programs; rather, government's position should be to facilitate the involvement of others and to encourage partnerships.
- Sexual assault, rape, and date rape are very much a part of the violence problem. When health officials study violence, they generally review death and hospitalization statistics. Although sexual assault injuries may not show up in their specific data sets as often as other types of violence, they are widespread, devastating, and traumatic.
- Violence must be understood as a reaction to economic, racial, cultural, sexual, and age-based oppression. Options to violence, therefore, must come from an understanding of the context of oppression rather than from a "blaming the victim" point of view. Currently, the Contra Costa community is creating a list of survival skills which it feels are necessary in developing options to violence. It will be important to teach these skills in a culturally competent manner.
- The issue of guns cannot be ignored since guns are the instruments most often used in homicides, assaults, and suicides.

- There must be recognition that males perpetrate most violence and that strategies to end violence must involve men in the solution.
- Adults, particularly parents and other caregivers, need to be part of the solution. One of the achievements of the Contra Costa County prevention efforts was the development of the Workplace Program, funded by the United Way. This project trains parents at their worksites in violence prevention, substance abuse prevention, and conflict resolution skills.
- In efforts to reduce violence, it is essential that youth themselves be part of the solution.
- The lessons about preventing posttraumatic stress that have been learned from wars need to be applied to inner cities. That is, we need to get to people quickly and to talk with them intensively.
- Understanding the complex relationship between alcohol, other drugs, and violence is critical and cannot be ignored in violence prevention efforts.
- Another key factor in violence is the presence and impact of the media. Regular television programming, for example, includes a large proportion of violence.
- Evaluation of violence prevention programs and strategies is critical.

Cohen noted that the mental health community has particular skills and expertise which are needed in violence prevention work. The mental health profession can contribute substantially to the field of violence prevention. For example,

because they have an understanding of how individuals work in groups as well as the skills necessary to advance a group's efforts, mental health professionals can assist in the promotion and maintenance of effective coalitions.

The mental health profession can also contribute a critical understanding of the effects of media on aggressive behavior and of the relationship between alcohol, other drugs, and violence. Communities and schools can benefit from mental health's conflict reduction and counseling skills. The mental health professions' knowledge on the issues of the effects of unemployment, of power and self-esteem issues, and of how posttraumatic stress disorder is associated with witnessing violence are critical. Mental health professionals can also make valuable contributions in understanding what is needed to ease the endemic burnout among individuals and groups working to prevent violence. Thus the linkage between mental health and public health communities can serve to save lives.

In conclusion, Cohen noted that it is important to find a new community solution to violence. This new solution suggests that the government must focus on violence as a public health issue, key organizations must work cooperatively, and prevention work must be based in local neighborhoods and schools. Most importantly, for a new community solution for violence to work, the dominant culture must share its authority and allow minority community leaders to become involved in planning as well as providing direct services.

Positive Adolescents Choices Training

Positive Adolescent Choices Training (PACT) is a violence prevention program for African American adolescents conducted by the School of Professional Psychology, Wright State University, in

cooperation with the Dayton, Ohio, public schools. W. Rodney Hammond, Ph.D., director of the program, stated that the lack of culturally sensitive training materials directed to the critical problem of interpersonal violence among African American youth led to the development of PACT.

PACT was built upon the premise that it is important to use peer role models to demonstrate the skills to be acquired to avert interpersonal violence, since adolescents tend to establish norms for behavior in reference to their own peer groups. Similarly, African American youth are oriented more to their own ethnic group for purposes of social comparison than to white adolescents, so that models which capture the distinct style of the subculture are more credible and convincing to them. Thus, Hammond noted, videotapes of peers of similar age and race, demonstrating appropriate behavior in conflict situations, are an especially desirable introduction to the learning of new skills. He and his staff found that, in existing violence prevention curricula and materials, there was a lack of videotape programs featuring African American role models. In addition, they found that many of the scenarios presented in existing videotapes and training materials were unrealistic in terms of the language, dress, and social interactions common to minority urban adolescents. Thus, the Dayton project developed and produced a videotape series entitled *Dealing with Anger: A Violence Prevention Program for African American Youth.* Funding for the initial project was obtained from the Ohio Commission on Minority Health and the Ohio Department of Mental Health. Under a grant from the MCHB, the program is being further developed and evaluated.

The *Dealing with Anger* program provides an introduction to youth training on three target social skills thought to be prerequisites for coping with anger or interpersonal conflict without resorting to expressive violence. These skills include:

1. *Givin' It* (Giving Negative Feedback) explores expressing criticism, disappointment, anger, or displeasure calmly. Use of the skill permits the participant to ventilate strong emotions constructively and mastery of the skill will set the stage for nonviolent resolution of disputes.
2. *Takin' It* (Accepting Negative Feedback) puts the participant on the receiving end of *Givin' It.* This skill involves listening, understanding, and reacting to criticism and the anger of others appropriately.
3. *Workin' It Out* (Negotiation) incorporates listening, identifying problems and potential solutions, proposing alternatives when disagreements persist, and learning to compromise.

Each skill is broken down into behavioral components which are described both in the videotape vignettes and on skill cards which can be given to group participants. The PACT videotapes present African American adolescent and adult role models, and the scenes depicted were developed in consultation with professionals familiar with the daily lives and concerns of the target population. In addition, PACT youth participants suggested scene content and provided feedback during the production of the materials. The training process involves introduction/modeling of target skills, including providing participants with a rationale for the value of the skill in preventing violence, and then offering the youth participants opportunities to practice the skill steps and receive feedback which will reinforce or correct their performance.

Hammond noted that current evaluations of the videotape program suggest that it is ideally suited for primary prevention with middle-school youth. Evaluations also indicate positive outcomes for participants in the program when com-

pared with a nonparticipating control group of youth. Initial findings indicate reduced school suspensions and changes in observable social skills, in addition to improvements in the way participants rate themselves and how they are rated by teachers.

Although effective, Hammond noted that the PACT approach is limited. First, it cannot, by itself, overcome problems within an intervention environment such as lack of trained and experienced staff who are comfortable working with African American youth. Second, the program chose to select only three of a vast set of target social skills. This leaves open the possibility that many other skills can and should be incorporated into future curricula utilizing this approach. Last, the program was not originally developed to rehabilitate older, more hard core, delinquent adolescents whose aggressive behaviors may be too deeply ingrained to rely solely on social skills training methods, although this approach may indirectly be successful with such youth as one component of a broader set of related services.

Future research should serve to clarify the range of settings and populations most likely to benefit from the PACT approach. Meanwhile, *Dealing with Anger* more clearly addresses the need for culturally sensitive violence prevention curricula.

A New Intervention Paradigm

The failure of our current systems to adequately and effectively address the extent and consequences of violence in African American communities was a recurrent theme and, indeed, was one of the factors that influenced the development of this particular workshop. Although MCHB can point to some efforts to address violence through its intentional injuries programs, very few mental health programs have developed effective program models to address either violence prevention or effective interventions for those children and families who are exposed to violence in their homes or communities. One of the underlying questions is why there has been such limited involvement of mental health programs in providing services to these children and their families.

Earl T. Braxton, president of Edge Associates in Pittsburgh, Pennsylvania, attempted to answer this underlying question in his presentation entitled "Violence Within and Without: The Failure of Mental Health Systems in Treating Angry Black Children." Braxton began by stating that the failure of the mental health system in general has been framed in the nation's approach to and understanding of mental disorder. The mentally ill have always been regarded primarily as deviants. In Biblical days, they were described as being possessed by demons or devils. In colonial America, they were regarded as witches—thereby designated, persecuted, and executed. The more recent "enlightened" view has been that mental disorders are an illness, and, like other illnesses, must be treated by caregivers specially trained to provide the professional attention the disease requires. With the Freudian revolution of the "unconscious," treatment practices became more humane, insightful, and sophisticated, but major problems still plague the mental health field. The focus of problems remains lodged in the patient or those manifesting symptoms of mental

disorder, while the treatment system and the environment remain unindicted and free of blame.

Further, the current social system in America evolved at the expense of certain of its members. African Americans were brought here in involuntary servitude and became an underclass group, a fact which continued long after the Emancipation Proclamation. Women and children were defined as property and chattel of men and had no rights. In such a social climate, the evolving mental health system was bound to reflect the issues of the prevailing culture and its norms. Despite all its progress, Braxton contends that mental health theories developed and evolved in a patriarchal environment that could not help but reflect some of the dysfunctional structures of the society. Braxton offered three propositions to depict the problem of the angry black child and the mental health system:

1. The mental health system has failed to adequately treat angry children or adults in general. This is particularly true if the person in question is nonwhite and male. It is as if black male anger cannot be tolerated, much less managed. This is primarily because anger is seen as bad and something that interferes with treatment. Consequently, anyone coming into the system for treatment who is angry cannot be treated until his or her anger ceases. This presents a profound contradiction since part of the reason the person comes for treatment is anger. The treatment model or paradigm is basically flawed and, therefore, dysfunctional for the task it was set up to perform.

2. The task of the mental health system is to facilitate the return to a state of mental/emotional health for those who came to it with problems (emotional or spiritual) that have caused an internal imbalance. This imbalance, taken to its extreme, is known as a state of mental dis-order or dis-ease [*sic*]. The disor-

der inside of a person invites two options for managing it. The system can attempt to either control the external situation or help the person put some order back into his or her internal situation, thereby regaining some control.

3. The mental health system's treatment paradigm is a dependency one based on the assumption that the patient/client, who is seen as helpless, vulnerable, powerless, victimized, wounded, and paralyzed, needs the help of the omnipotent, powerful, all-knowing, wise, insightful, strong, able therapist or helping professional. The system is structured to protect the omnipotence of professionals and ensure the dependency of the patient.

Braxton noted that our current mental health approaches do not facilitate recovery, which is equal to attaining a certain level of independence and self-management as opposed to self-control. We reinforce our clients need for external control rather than focusing on the development of their own internal controls. External controls, Braxton said, require secure facilities, police and guards, and strong medication. Along with medication comes the dependency on the experts who *know* how much you need, whether you need it, what is good for you, and what is not, etc. Meanwhile, patients/clients who are overwhelmed by the experience become more and more disabled by their dependency.

To enter into a truly collaborative approach to mental health and physical health—one that works—is very different and requires a different set of skills and expertise. A collaborative model:

- Enables patients to risk growing and finding themselves, rather than the system running a rescue mission on their behalf;
- Enables patients to be partners with the helping professional, and to take some responsibility for the healing process;

- Focuses on facilitating self-help rather than dependency;
- Feels harder and more demanding initially; and
- Requires the professional to bring more of self to the interaction and spend less time veiled in the professional role.

The average staff person is not trained in a collaborative model of working with clients within the mental health system. Rather, people have learned "techniques" as their tools, and patients are required to fit the techniques. When they do not fit, the treatment failure is placed on the patient. The failure of treatment then becomes the patient's problem and the professional is off the hook. Some of the areas that have been neglected in the preparation of staff are:

- How to "hold" (meaning stay connected with) a person who is in pain—emotional, spiritual or physical.
- How to empathize with those who are behaving in ways that are revolting to us. No matter how despicable one finds the person, we must learn/accept the struggling or lost spirit inside even while we reject the behavior on the outside.
- How to allow someone to be angry at, with, or around us without succumbing to our own reactions or judgments.
- How to know the difference between their space and ours. This is vital training for working with troubled children and adolescents. When the adult fails to maintain some distinction between himself/herself and the acting out child or adolescent, the child inside of the helping adult gets "hooked" and the therapeutic view of the problem is lost.
- How to hold people accountable, no matter how much it hurts (them or us).

- How to be fair, but firm.

The absence of learning in these areas prevents mental health staff from truly becoming partners with their clients and from managing the healing process. What they learn instead is how to control the situation. Healing is then retarded because the client is not integrally involved in the pursuit of wellness.

Braxton believes that angry African American children become victims in such a mental health system. Their anger is used against them and practitioners are more often frightened by the children's emotional expression than concerned about what's beneath it. Below all anger and rage are the more powerful causal emotions, usually some combination of fear, vulnerability and pain. The feelings are often set off by secondary factors such as frustration, resentment, hatred, abandonment, and intrusion. The violence expressed outwardly is the road map to the degree of inner fear, pain, and vulnerability.

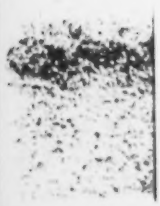
African American children, Braxton noted, come from an African heritage of family centeredness, valuing children as well as adults within the extended family. Faced with the painful and violent experience of growing up in today's urban environments, African American children learn to survive by behaving as if those things do not matter. For an oppressed group, however, survival is not enough.

Angry African American children suffer from: (a) a sense of disempowerment and lack of control over their lives; (b) a sense of hopelessness/helplessness (dependent); (c) no history around which to build a positive self-image; (d) feeling violated; (e) feeling abandoned; and (f) having lost the boundaries

between self and a destructive or disorganized environment. If the mental health system is going to be able to provide effective treatment for these young people, it must encompass the following elements:

- Teaching assertiveness (aggression is the absence of assertiveness).
- Recruitment and training of practitioners and professionals who are not afraid of their own anger, and, therefore, not afraid of the child's.
- Retraining of parents.
- Retraining of teachers.
- Education for freedom (and responsibility), not control.
- Adoption of a collaborative model, which holds children both accountable and responsible, but does not foster dependency.
- Practitioners who can keep their feelings and thinking process in the same place while providing services to the children.
- A conscious effort to build self-esteem through learning more about African American history and heritage.

Angry African American children, Braxton concluded, need to be taught to take up responsible roles in the society in which they live. In order for that to happen, the mental health system needs a new treatment paradigm and new training for practitioners.



New Directions

There is little consensus regarding the causes of high rates of violence in African American communities. Traditional theories that focus on "cultures of poverty," lack of self esteem and impulse control among African American youth, inadequate or deviant socialization, or increased drug abuse or drug trafficking, tend to overestimate those engaging in violence and do not offer adequate explanations about the interpersonal and intrapersonal processes associated with African American violence (Oliver 1989).

Three workshop presenters—William Oliver, Aminufu Harvey, D.S.W., and Amos Wilson—addressed alternative theoretical frameworks from which to more adequately assess and understand African American community violence. All three presenters stressed the need to develop an Afrocentric approach to understanding and combatting violence in African American communities.

Each of these presenters utilized a theoretical framework that endorsed community self-help and definition of the problem. All three viewed African American violence as essentially a reaction to white oppression and dominance. They emphasized the need for enhancement of Afrocentric values and culture to combat the American system that leads to powerlessness, self-hatred, and lowered self-esteem for so many African American youngsters, especially males. The African American community must provide avenues for the positive expression and enactment of African American male roles that offer an alternative to the distorted masculinity models copied from the dominant society or developed to defend against these models.

These scholars suggested that African American violence can only be understood within the current context of the powerlessness within these communities and the need of African Americans to have some sense of self-control and achievement, both on the

individual and community levels. A clear assumption is that the primary emphasis should be given to programs and strategies that encourage and enhance self-help opportunities within African American communities.

Currently, there are very few violence prevention or intervention strategies rooted in the context outlined by these presenters, although the use of Rites of Passage programs and ceremonies is increasing. These programs have similar characteristics.

- They provide a group of committed adult males (and females) who will lead African American boys through the passage from boyhood to manhood.
- They incorporate and teach African values and principles.
- They redefine manhood and provide manhood training from an Afrocentric perspective.
- They provide an opportunity for positive and productive socialization into adult roles.
- They provide cultural enrichment, sex education, educational reinforcement, and life management.

There is also a growing debate about Afrocentric approaches to education and the need for specialized schools (immersion schools) for African American males.

William Oliver, a professor in the Criminal Justice Program at the University of Delaware, described a culturally oriented community development agenda that has been designed to reduce the disproportionate rates of community violence among African Americans. This agenda is based on the belief that structural reform of American political, economic, and education systems, though necessary, is not enough to substantially reduce the high rates of social problems among African Americans. Rather, such

reforms must be coupled with a cultural transformation in order to enhance cultural confidence and fortify African Americans against the adverse effects of institutional racism.

Oliver's structural-cultural perspective rests on a fundamental assumption that the disproportionate rates of criminal violence among African Americans are a product of structural pressures and dysfunctional cultural adaptations to those pressures. More specifically, Oliver suggested that historical and contemporary social practices involving institutional racism—that is, the systematic deprivation of equal access to opportunity—have prevented a substantial number of African American males from achieving manhood through legitimate means. African American males who adhere to the compulsive masculinity alternative define manhood in terms of overt toughness, sexual conquest, manipulation, and thrill-seeking. It is inevitable that these exploitative and unreciprocal role orientations would produce a unique set of motives and justifications for assault and homicide among African American males.

Believing that the high rate of African American interpersonal violence is a product of cultural misorientation and disorganization, Oliver emphasized an Afrocentric Community Development Agenda built on the following ten points:

1. Black people must redefine themselves as African Americans. A positive collective identity is essential to social progress. The term *African American* will help to counteract the myths and stigma associated with white America's definition of black people as niggers, coloreds, and Negroes.

2. African Americans must adopt an Afrocentric worldview. African Americans will never make any substantial progress as long as they continue to accept as legitimate a Eurocentric worldview that is at its core anti-black. The internalization of

the Afrocentric worldview would maximize black cultural unity through its emphasis on "collectivism," "spirituality," and "oneness with nature."

3. African Americans must socialize their children to internalize an Afrocentric value system. As racism is real in America, so too is "self-perpetuating pathology" among African Americans. Academic failure, adolescent pregnancy, substance abuse, and black-on-black crime are much more than products of white racism. These social problems are also products of dysfunctional cultural adaptations to white racism. Thus, African American parents and community organizations must begin to socialize children to internalize values that emphasize an Afrocentric worldview—that is, a worldview that encourages love of self, respect of the African heritage, and commitment to African American unity and progress.

4. African Americans must help their children achieve excellence in education. The ability to read, write, analyze, and calculate are absolutely essential in order to achieve a decent standard of living. Too many African American adolescents are dropping out of high school. African American parents must become more actively involved in the education of their children. The school must be redefined as a community institution that exists to prepare African American youth to function effectively in society.

5. African American leaders and institutions must recommit themselves to the survival and progress of African Americans. Maximizing cultural unity in order to implement a nationwide program of African American self-help must become a primary goal. The effectiveness of African American leaders and institutions must be judged by the extent to which they work to

reduce the high rates of social problems among African Americans. The Afrocentric agenda demands accountability to the collective objectives and interests of African Americans.

6. African Americans must restructure their religious theologies and churches to play a major role in encouraging African American cultural unity and self-help. Much has been written about the centrality of the African American church. The high rates of social problems among African Americans, however, suggest that the contemporary African American church is not the powerful agent of moral development and social control that it once was. In order to restore psychological and cultural stability, African Americans must reject all religious theologies and symbols that have been used to justify their exploitation and oppression.

7. The African American middle class must reach back and help those less fortunate than themselves. The African American community is losing too many of its educated people to lifestyles structured around individualism and materialism. This is primarily due to the fact that middle class African Americans have not been socialized to internalize an Afrocentric or collective orientation. African American leaders and institutions must work to create programs that attempt to reunite the African American middle class with the African American underclass.

8. African Americans must declare war on drug dealers and others who engage in behaviors that disrupt the black community. Individualism and passivity among African Americans have contributed to the emergence of a mentality that says anything goes in the black ghetto. The African American community must reclaim crime-ridden neighborhoods from those who are

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out of control by staging anti-drug rallies, patrolling neighborhoods, and providing community-based social services.

9. African Americans must work to develop their own businesses. Achieving African American cultural unity is not likely if African Americans do not strive to achieve economic independence. Economic development is critical if African Americans are going to reverse the growth of the underclass.

10. African Americans must network to purchase and develop mass media organizations (e.g., newspapers, magazines, and radio and television stations) in order to produce media products that communicate the facts about African Americans.To counteract cultural racism and the negative images of African Americans that are frequently disseminated by the mass media, African Americans must establish mass media that address their most fundamental psychological and cultural needs.

In conclusion, Oliver noted that prevention strategies designed to reduce disproportionate rates of criminal offenses and criminal victimization among African American males will continue to fail if efforts are not undertaken to address the adverse effects of cultural racism. He suggested that self-help is the most important feature of the Afrocentric agenda. Such self-help includes establishment of Rites of Passage programs for youth; greater entrepreneurship (business development); a focus on job training and development; striving for excellence and multiculturalism in education; and restructuring religious theology so that African American churches become more involved in the daily activities of the community.

In his presentation, "Violence: A Reaction to Racial and Cultural Oppression," Aminufu Harvey, executive director of the MAAT Center in Washington, D.C., discussed the etiology of violence by

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African American youth, its psychological dynamics, and a comprehensive intervention model. Harvey noted that the violence in African American communities is manifested in several ways:

1. Through incidents such as those in Bensonhurst, New York, or police brutality such as that experienced by Rodney King in Los Angeles, which are examples of racial and cultural oppression;

2. Through increasing suicides—a form of self-inflicted violence which runs counter to the entire African American cultural heritage; and

3. Through "black-on-black" violence—behavior which is self-inflicted, self-abusive, leads to abuse of others, and ultimately leads to the abandonment of families.

Essentially, Harvey postulated that the current violence seen in African American communities is the direct result of psychological oppression of African Americans by the white power structure. He noted that after years of experiencing abuse, neglect, and abandonment, we begin to internalize the myths of Africans having no culture and to identify with the oppressor. This self-alienation and blocking of transitioning through each stage of development leads to feelings of hopelessness and helplessness which equal perceived powerlessness.

The externalization of perceived powerlessness is exhibited in anger, which is destructive to others and the community and ultimately results in murder/fratricide. This powerlessness leads to two primary emotions: depression and anger. The state of depression is a process by which an individual, family, or community elicits acts which destroys itself. First psychologically and then physically, we see drug abuse, prostitution, and alcoholism as slow suicides. When perceived powerlessness is externalized, it is exhibited as anger or

rage. Usually the anger, which results in homicide, is acted out upon what is closest and that which will receive the least retribution from the larger society—namely, killing another African American.

In order to combat perceived powerlessness, which is the natural initial reaction to oppression among African American youth, Harvey suggested that we must go back to cultural orientations and look at models indigenous to African American communities that have worked, such as the Nation of Islam activities. The common factors that seem to mark successful community interventions are:

1. Spirituality (or religious orientation);
2. Economic resources (addressing jobs and other means of production);
3. Educational institutions (having own schools and own media outlets);
4. Cultural foundation (understanding the importance of the past); and
5. Strong male presence (the notion that males must protect and provide for the community).

Harvey suggested that an adolescent Rites of Passage program is one appropriate modality that can be used to bring youth into manhood. He believed that only with the incorporation of an African world view and values will we be able to provide the inoculation and treatment models necessary to address the issue of African American violence. He also believed that this approach allows for change or transformation to occur at multiple levels—at the behavioral, emotional, cognitive, and spiritual levels. Violence prevention and intervention must be able to address these multiple levels to be effective.

Finally, Amos Wilson, author of *Black-on-Black Violence: The Psychodynamics of Black Self-Annihilation in Service of White Domination*, also discussed white supremacy as the primary causal factor in African American criminality and violence. As Wilson (1990) stated in his book: "Black men kill each other because they have not yet chosen to challenge and neutralize on every front the widespread power of White men to rule over their lives" (p. xiii). Therefore, in Wilson's view, African American violence is a natural outcome of continued oppression by the white majority. He also believes that it is important to focus on the fact that unemployment, underemployment, poor education, poverty, and drugs, which are often cited as causal factors in theories about violence, are tangibly related to African American violence, but represent its secondary effects rather than its causes.

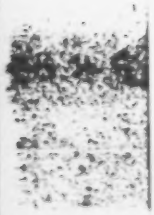
Wilson noted that violence is not aberrant to the American society; rather, it is commonplace. The slaughtering of Native Americans and the enslavement of Africans are two historic examples of the use of force and violence by European Americans to subjugate peoples different from themselves. Current African American violence represents a new dimension of oppression that serves a similar function as slavery and other oppressive acts in America's past. The sophistication of white oppression, however, is now such that African Americans have become the primary and visible destroyers of their own people. Wilson emphasized that African American violence serves a very important function in American society—justifying and rationalizing white supremacy.

On the psychodynamic level, Wilson suggested that the internalization of white domination and oppression leads to self-hatred and self-alienation, thus setting the stage for African American violence. Given the widespread impact of the social and psychodynamic patterns that result from racism, Wilson stated that the

question is not why there is so much African American violence, but rather why it is not even more widespread.

In order to counteract racism and its effects, Wilson suggested that there must be a transformation of African American manhood. This can only come about through the appropriate education and training of African American youth. Currently, the formal and informal education of African American youth is an education in alienation, self-abnegation, incompetence, unreality and wrongheadedness. African Americans are, therefore, educated against their own interests, which is one of the reasons that, despite their sizeable educated, professional, and trained classes relative to other groups, their economic and political power is benign and their survival is in question. Thus, if African American youth are to be educated away from their "anti-social" proclivities and educated in ways that permit them to legitimately actualize their human potential, they must receive an Afrocentric education, especially during their impressionable years, and they must be taught by their own elders.

Wilson concluded by stating that it is important for the African American community to understand that violence has real and tragic consequences and ultimately lessens the survival of African American people. It is imperative that African American communities successfully neutralize and/or markedly decrease criminal activity within their domains. In addition to the development and furthering of Afrocentric education for African American children, Wilson believes that African American communities must take their destiny into their own hands. They must take responsibility for building and providing adequate housing and employment for their constituents. They must also rebuild, re-create, and create African-based cultural and moral values for families and children.



Recommendations

After the presentations, workshop participants addressed three issues. Their discussions and recommendations for each of these issues are presented below.

Issue 1

What are the key factors/issues that must be addressed, by states and their local communities, in their attempts to develop prevention or treatment interventions for African American children and their families?

One of the first factors that needs to be addressed is the conceptual framework that is used to define violence. It was believed that community violence must be redefined as an American problem and not just a problem of the African American community. It then would be viewed as a public health issue which has reached epidemic proportions and which requires attention and amelioration. As long as violence is seen as the outcome from a "deviant" community and "blaming the victim" theories inform policy and program development, attempts to address the issue will be ineffective. In the reconceptualization of violence in African American communities it is important to recognize the role that oppression, unequal opportunities, discrimination, and poverty play in its development and perpetuation. Violence must be viewed as the reaction to the interaction between a dominant and minority culture that depends on the denigration of the African American group.

Therefore, the second critical factor in addressing violence is the need to re-educate and "change the change agents." This means that public health and mental health professionals, teachers, providers, parents, and adolescents must be trained in a way that allows them to more effectively understand and resolve issues

of violence in African American communities. At the present time, these professionals and families do not have the requisite knowledge and skills to effectively intervene. And yet, the way a problem is defined determines its solution. To date, violence has been viewed primarily from a law and order perspective. A comprehensive understanding of violence is far more complex, however, involving many different institutions in American society and subject to the various attitudes, beliefs and values that Americans hold about African Americans.

The participants recognized that there is a need for a comprehensive community violence policy and prevention strategy that defines community violence as a product of multiple causes and as a problem that requires multiple solutions. Another overriding issue is the current lack of culturally competent prevention efforts at the four levels of intervention: the consumer, the practitioner, the policymaker, and the administrator. Projects such as PACT (Dayton, Ohio) and the community projects in Richmond, California, and Boston, Massachusetts, need to be encouraged and more widely disseminated.

One of the key factors that emerged from the theoretical presentations and the prevention program examples is that the community and target population must be involved in planning and finding the solution to the problem. Self-help and community empowerment emerged as critical ingredients in any successful prevention and intervention techniques. There must be a shift in thinking from doing *to* people to doing *with* people. It is also important that all prevention strategies and interventions include positive value orientations, such as those values that are incorporated in Rites of Passage programs. Individual youth, families, and African American communities need to adopt value orientations that enhance respect and esteem.

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The workshop participants also identified the following specific factors or issues that must be addressed by states or local communities in any attempts to develop or plan for violence prevention in African American communities:

1. States and local communities need to give priority to violence prevention for African American families and designate special funds without detracting from service funding. There is also a need to better connect prevention with remediation.

2. Effective violence prevention and reduction must involve many different groups and agencies. The state or local community must try to determine who the 'players' are in the system in order to facilitate a collaborative cross-systems approach.

3. There should be one central state or local agency designated to coordinate the collaborative systems planning and service delivery. There are risks, however, in designating one agency as the lead: (a) other agencies may opt out at some point and time; and (b) a lead agency such as mental health carries the possibility of prematurely "labeling" children. These risks must be carefully addressed.

4. The efforts at the state level must support development at the local level with consideration for selecting a diverse group (i.e., allowing health, child welfare, mental health, juvenile justice, substance abuse, or another agency to take the lead based on the needs of each local community).

5. Services should be organized to facilitate delivery in the most normative environment (e.g., home, school, and other community settings).

6. States should ensure that the issues of injury and violence are incorporated in formal planning processes conducted by mental health, health, education, and other agencies.

7. Schools are central to the development of local service systems, and networks, and the identification of problematic behaviors.
8. There should be a special focus on child welfare agencies and ways to involve them, given their responsibility to provide protection for abused and neglected children and given the relationship between domestic violence and community violence in African American communities.
9. Education and training at colleges and universities must be modified to provide different skills and knowledge based on an ideology which recognizes the needs of children and families who are victims of violence.

Issue 2

What are the roles and responsibilities of mental health agencies and maternal and child health agencies in addressing the issue of violence and violence prevention? Identify the opportunities for and barriers to productive collaboration between these two agencies.

The workshop participants recognized that neither mental health nor maternal and child health agencies have adequately addressed the issue of violence prevention and intervention in African American communities—even when they provide services within these communities or serve large numbers of African Americans in their target populations. The presentations on the effects of violence on children and the lack of mental health interventions suggest that mental health agencies need to begin to review their practices and understand the critical impact that witnessing violent acts or living in high-violence communities has on the physical and psychological development of children. To date, there have

been only a few mental health programs that address inner-city violence and even fewer that offer specialized services. This is to be contrasted with the involvement of mental health professionals in preventing trauma in children during the war in the Persian Gulf, as well as the mass of research that has been conducted to look at the impact of war on children in other countries.

The group believed that some of the expertise and findings from these efforts should be used to inform and make more urgent the need to address the damage being perpetrated on inner-city children who live with the threat of violence every day of their lives.

Although maternal and child health has been more aware of violence prevention, and has funded several projects, these efforts have been relatively small and have not been accorded priority status in the agency. For the most part, these activities have not specifically addressed culturally competent approaches to intervene with African American communities and youth.

Consequently, the groups looked at the roles and responsibilities of these agencies in addressing violence prevention and early interventions in African American communities. The following suggestions were made.

Planning

There are many opportunities for federal and state mental health and maternal and child health agencies to address the issue of violence within their already established planning processes. For example, the state Maternal and Child Health Block Grant applications must address the year 2000 objectives established by the Department of Health and Human Services (DHHS). Violence reduction is one of the chapters in *Healthy People 2000*. Moreover, in the state maternal and child health needs assessment, high death rates due to homicide among subpopulation groups is a compelling case

for action. States with excessive rates of adolescent homicide, child abuse, and adolescent suicide should address activities related to these issues in their annual Title V applications and plans.

Similarly, the Mental Health State Planning Act, P.L. 99-660, establishes a planning process which could provide an opportunity for mental health agencies to begin to address the issues of violence prevention and intervention. A key component of the planning process requires interagency collaboration. Through their Child and Adolescent Service System Program (CASSP), child mental health authorities in the states have received funding for such interagency activities. Some of these efforts could focus on addressing violence prevention and the high risks for children associated with constant exposure to violent activities.

Another focus of CASSP incorporated in the P.L. 99-660 planning process is the need to develop culturally competent systems of care. If this principle is to be met, then certainly mental health agencies should be addressing violence when it has a major impact on large proportions of children of color within their planning jurisdictions. Under P.L. 99-660, states can also address at-risk populations that are defined and identified by the state. Therefore, states with excessive rates of adolescent homicide, adolescent suicide, and children exposed to violence can identify these groups as at-risk populations and can develop goals and objectives to address remedial actions in their plans. To date, however, few states have addressed violence prevention or exposure to community violence as a factor placing children at risk for emotional maladjustment.

The group believed that these planning processes could be more effectively used to identify violence as an important issue and to provide a higher level of visibility. In addition, the plans can be used to target groups, such as African Americans, that are disproportionately affected by exposure to violence in their communities.

Joint Leadership and Collaboration

The group recommended that mental health and maternal and child health staff initiate and provide leadership for joint collaborative efforts at the federal, state, and local levels. There was a belief that the collaboration between the two agencies, as well as the involvement of child welfare, education, and juvenile justice, was critical to the development of effective strategies and a comprehensive approach to the problem. Joint collaboration could focus on three major areas: (1) problem identification via research and evaluation activities; (2) training of professionals and community leaders; and (3) services/program development.

Another way to address the importance of collaboration and to provide a higher level of visibility to the issue of violence would be to establish a state Office of Violence Prevention that would require the participation of all child and family agencies. Such an office could serve as a clearinghouse for information; initiate research, evaluation, and program development; and provide policy direction to the state in this area. For those states with established Offices of Minority Health, these offices may act as the clearinghouse, but maternal and child health and mental health would be expected to collaborate and provide some funding for a special focus on violence prevention and intervention for African American communities.

Recruit and Utilize Experienced and Culturally Competent Professionals

The group noted that there are many professionals of color with expertise and knowledge in the area of violence prevention and interventions; however, they are not currently employed or consulted by federal, state, or local agencies trying to address these problems. Therefore, one of the roles and responsibilities of mater-

nal and child health and mental health agencies should be to recruit experienced and culturally competent professionals and consumers to provide technical assistance in problem identification, program development, training, and evaluation.

Federal and state agencies should also identify and recruit culturally competent practitioners and professionals to be on grant review panels to ensure that more of these issues are addressed in grant awards. Maternal and child health and mental health agencies, at the federal and state levels, should encourage minority communities and agencies to apply for funding under their various grant programs and provide the necessary assistance to help them understand the process and submit competitive applications.

Issue 3

Suggest specific next steps that a state or local community could take to prevent or effectively intervene in African American community violence.

1. One of the most important barriers to the development of effective activities and strategies in this area is the lack of data. NIMH and MCHB should sponsor and support interdisciplinary research on the impact and effect of violence on children and families in inner cities, as well as the relationships between violence, poverty, unemployment, and lack of economic opportunity. Funds also should be provided for development and evaluation of effective program models in addressing these issues.

2. Information and funding must be made more accessible to minority researchers and program developers. Federal agencies and states should develop more specific strategies for identifying and encouraging research and program development by minority professionals.

3. Protocols and curricula should be developed within the institutional training programs supported by MCHB and NIMH so that practitioners are given knowledge and skills necessary to assist victims of violence.

4. Mental health and maternal and child health staff should develop a contemporary statement of problems currently faced by agencies in serving African American populations with high exposure to community violence. This should be communicated to colleges and universities to influence the training of current students in human service disciplines.

5. The federal agencies should create an alternative learning structure (consortium, collaborative, or institute) which would: (a) integrate research and practice; (b) emphasize program design, policy development, and alternative approaches; and (c) provide a new learning base to train and retrain practitioners working with violence in the health and mental health arenas.

6. States should undertake activities that focus on increasing awareness and improving information sharing about the impact of violence on children and families. Such activities could include executive briefings, brown bag lunches within agencies and across agencies, discussions on public access television, or call-in radio shows.

7. NIMH and MCHB, as well as state agencies, need to develop more effective dissemination techniques and strategies for information that is already known. Dissemination approaches need to be geared to the particular target audience that needs to hear the message. Agencies also should learn ways to better use the media to present their messages about the critical importance of violence prevention and the impact of violence on children.

8. Government agencies should begin to work with the business community and other agencies that are affected by or have a stake in the reduction and prevention of violence.

9. The most effective programs seem to be those focused on prevention/early intervention addressing the child and family at risk. Therefore, state budget priorities should reflect a priority given to prevention/early intervention strategies.

10. Mental health should be included in the planning for prevention programs. Some priority should be given to planning for early intervention services for children exposed to violence. Such children should be viewed as being at high risk for mental health problems.

11. Cost-effective programs that seem to address multiple solutions to the multiple problems at the root of violence are those that focus on conflict resolution and mediation skills. Therefore, states and local communities should establish programs that teach conflict resolution skills to children and adolescents (grades K–12); conflict resolution skills to parents, church leaders, and community organizers; and mediation skills. These programs should be developed in a manner that reflects culturally competent approaches and materials for the targeted population.

12. Health, mental health, and social services screening and intake forms should be amended to include and gather information on a child or family's exposure to or experience with violence. Oftentimes, this information is simply not addressed in the intake processes of these agencies.

13. Interagency, interdisciplinary training opportunities should be made available to state and local government staff and providers working in African American communities or with

large numbers of African American clients so that they can become more aware, more knowledgeable, and more skillful at addressing and finding solutions to the impact of violence on children and families. Interagency and interdisciplinary training should be given so that all providers can begin to speak a common language and begin to develop a consensus on the risk factors that need to be addressed to prevent or reduce violence and its impact.

14. Funding of grants in mental health and maternal and child health should provide incentives for applicants to develop and acknowledge strong, powerful community ownership of the violence problem. Applicants should have to demonstrate total community involvement in the project and support from indigenous community agencies as well as agencies such as the Urban League, the United Council of Churches, and the United Way.

15. Federal and state agencies should fund more intervention programs developed by minority professionals or organizations. Organizations within minority communities, such as historically black colleges, should be encouraged to participate in violence prevention and early intervention activities and strategies. Economic opportunities should be a key component of violence prevention and intervention strategies in African American communities.

16. States should examine the use of victims assistance funds and the redirection of funds from juvenile justice detention facilities for prevention activities.

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Appendix A: Conference Agenda

June 13, 1991

Opening Session
8:30 a.m.—10:45 a.m.

Welcoming Remarks

NIMH CASSP Program
Judith Katz-Leavy

Maternal and Child Health Bureau
Jean Athey, Ph.D.

New York State Office of Mental Health
Gloria Newton-Logsdon

New York City Department of Mental Health, Mental Retardation andAlcoholism Services
Billy Jones, Jr., M.D.

New York City Maternal and Child Health Services
Allan S. Noonan, M.D.

Introductions and Workshop Goals — Mareasa R. Isaacs, Ph.D.

Keynote Address: An Overview of the Nature, Extent, and Consequences of Community Violence in African American Communities.
Beverly Coleman-Miller, M.D.

11:00 a.m.—12:30 p.m.
Understanding Community Violence Among African Americans

A Structural-Cultural Perspective — William Oliver

A Reaction to Cultural amd Racial Oppression — Aminufu Harvey, D.S.W.

1:30 p.m.—2:30 p.m.
Overview of Prevention Programs to Address Community Violence in African American Communities: Descriptions and Program Effectiveness

Renee Wilson-Brewer

2:30 p.m.—5:00 p.m.
Panel: Program Models for Violence Prevention Efforts Focused on African American Youth and Families

Massachusetts	*California*	*Ohio*
Paul S. Bracy	Larry Cohen	W. Rodney Hammond, Ph.D.

June 14, 1991

9:00 a.m.—10:30 a.m.
The Impact of Community Violence on the Development of African American Children: Socio-cultural Issues and Protective Mechanisms
Hope M. Hill, Ph.D.
Carl J. Hampton, Psy.D.

10:45 a.m.—Noon
Violence Within and Without: The Failure of Mental Health Systems in Treating Angry Black Children
Earl T. Braxton, Ph.D.

1:30 p.m.—2:30 p.m.
Review of the Salient Research on the Impact of Violence on Children
Malcolm Gordon, Ph.D.

2:30 p.m.—2:45 p.m.
Instructions for Small Groups — Mareasa R. Isaacs, Ph.D.

3:00 p.m.—5:30 p.m.
Small Group Discussions
Group A. Facilitator: Nancy Ware
Group B. Facilitator: Regenia Hicks, Ph.D.
Group C. Facilitator: Marva P. Benjamin
Group D. Facilitator: Kenley R. Wade

June 15, 1991

9:00 a.m.—10:00 a.m.
Panel Review and Discussion of Issues/Recommendations from Small Groups
Facilitator: Aminufu Harvey, D.S.W.

10:15 a.m.—11:15 a.m.
Keynote Address: Benign Neglect of the Black Family and Community—The Causal Relation to Black Juvenile Violence
Amos Wilson

11:15 a.m.—11:45 a.m.
Children Survivors of Homicide Victims Chorale—from the Brooklyn Office of Victims Services

11:45 a.m.—Noon
Closing Remarks — Maxwell C. Manning

Appendix 3: Annotated Bibliography

Center to Prevent Handgun Violence. (1991). *Facts about children and handguns.* Washington, DC: Center to Prevent Handgun Violence.

This one page fact sheet provides statistics and epidemiological data on children, ages 19 and under, who are victims of homicide and suicide. The growth in firearm wounds and homicides since 1984 is documented. Data are provided on the number of children who carry guns to school and who have access to guns.

Contact: Center to Prevent Handgun Violence, 1225 Eye Street, N.W., Suite 1100, Washington, DC 20005. Telephone (202) 289-7319. Multiple copies are available at no charge.

Children's Safety Network. (1991). *A data book of child and adolescent injury.* (1991). Washington, DC: National Center for Education in Maternal and Child Health. (703-524-7802).

This book provides current statistics on the level of mortality and morbidity among America's youth due to violence and other injuries. Includes homicide, suicide, assault, sexual assault, and child abuse information.

Contact: NCEMCH Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, VA 22031. Telephone (703) 821-8955, ext. 254. Single copies are available free of charge.

Children's Safety Network. (June 1991). *MCH Program Interchange: Focus on Violence Prevention.*

A listing of recently developed local and state resources for health departments and practitioners on violence prevention. Includes curricula, videotapes, evaluations of interventions, manuals, reports, brochures and fact sheets.

Contact: NCEMCH Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, VA 22031. Telephone (703) 821-8955, ext. 254. Single copies are available free of charge.

Cohen, Stu and Wilson-Brewer, Renee. (1991). *Violence Prevention for Young Adolescents: The State of the Art of Program Evaluation.* Carnegie Council on Adolescent Development, Working Papers. Carnegie Corporation of New York.

Presents recommendations from a conference supported by the Carnegie Foundation in 1990 on violence prevention for young adolescents. Conference participants shared their expertise and experiences with evaluation.

Contact: Carnegie Council on Adolescent Development, 2400 N St., NW, Washington, D.C. 20037-1153, (202) 429-7979. Single copies available free of charge.

Hammond, W. R. (1991). *Dealing with anger: Givin' it, takin' it, workin' it out —A violence prevention program for African American youth.* Champaign, Il: Research Press.

This training program includes a leader's guide, skill cards and three videotapes to help community leaders and school personnel teach African American youth social skills for appropriately dealing with anger.

Contact: Preview copies available from Research Press, at 217-352-3273.

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LaCerva, V. (1990). *Let peace begin with us: The problem of violence in New Mexico.* Santa Fe, NM: New Mexico Health and Environment Department.

This book provides a model for the presentation of county-by-county information on a range of violence issues. A list of 15 questions to help practitioners assess how their community rates on violence prevention activities is included. Recommendations address legislation, agency policies, data collection, community action and public education.

Contact: Victor LaCerva, M.D., F.A.A.P. Medical Director, Maternal and Child Health Bureau, New Mexico Health and Environment Department, 1190 St. Francis Drive, Santa Fe, NM 87504. Telephone (505) 827-2351.

Michigan Child Mortality Review Panel. (December 1991). *Violent Deaths to Children: A Growing Risk to Growing Up in Michigan. A Report to the Directors of the Michigan Department of Public Health and the Michigan Department of Social Services.*

This report is a model for reporting on a statewide inquiry into the impact of violence. The report identifies key findings related to data on homicide, the role of firearms, and those at highest risk. It presents five recommendations addressing community coalitions, state legislation on firearms accessibility, education, the role of the public health department, and the establishment of a surcharge on the sale of ammunition and firearms to fund violence prevention programs.

Contact: John B. Waller, Jr., Dr.P.H.,Panel Chair. Department of Community Medicine, Wayne State University, School of Medicine, 540 East Canfield, Room 1369, Detroit, Michigan 48201.

National Committee for Injury Prevention and Control. (1989). *Injury prevention: Meeting the challenge.* Oxford University Press.

Chapters devoted to violence prevention explore assaultive injury, child abuse, domestic violence, elder abuse, rape and sexual assault, suicide and firearm injury. Each chapter describes the magnitude of the intentional injury problem, risk factors, prevention, interventions and recommendations. Possible collaborators and funders in injury prevention are also described.

Contact: NCEMCH Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, VA 22031. Telephone (703) 821-8955, ext. 254. Single copies are available free of charge.

Northrop, D. and Hamrick K. (1990). *Weapons and minority youth violence.* Newton, MA: Education Development Center.

This background paper was prepared for a Forum on Youth Violence in Minority Communities, and focuses on gun violence and intervention issues. Interventions are placed in three categories: educational and behavioral, legal, and technological and environmental. Interventions were then described as current or potential.

Contact: Division of Injury Control, CEHIC, Mail Stop F36, Centers for Disease Control, Atlanta, GA 30333.

Northrop, D., Jacklin, B., Cohen, S., and Wilson-Brewer, R. (1990) *Violence prevention strategies targeted towards high-risk minority youth.*

This background paper was prepared for a Forum on Youth Violence in Minority Communities and presents issues for intervening with high-risk minority youth. High-risk groups were described as were some existing interventions and their effectiveness, and other potential interventions.

Contact: Division of Injury Control, CEHIC, Mail Stop F 36, Centers for Disease Control, Atlanta, GA 30333.

Prothrow-Stith, D. with Weissman, Michaelle. (1991). *Deadly Consequences.* New York: Harper Collins Publishers.

A wide range of violence issues are presented, including violence from television and other media, gangs, substance abuse, and involvement of family, school and community. Also presented is a range of related risk factors such as socioeconomic status and race/color and a state-by-state listing of violence prevention programs with contact information, populations served and intervention descriptions.

Contact: Department 361, Harper Collins Publishers, 10 East 53rd Street, New York, NY 10022-5299. Telephone (800) 331-3761.

Prothrow-Stith, D. (1987). *Violence prevention curriculum for adolescents.* Newton, MA: Education Development Center.

This curriculum is a 110-page teacher's guide (with student handouts) and a teacher-training videotape. The 10-session course offers positive ways to deal with anger and arguments, the leading precipitants of homicide among adolescents.

Contact: Millie LeBlanc, EDC Publishing Center, Education Development Center, 55 Chapel Street, Suite 24, Newton, MA 02160. Telephone (617) 969-7100. Videotape and teacher's guide are available for $150.00; teacher's guide, $15.00; videotape rental and teacher's guide, $60.00.

Rosenberg, M. and Fenley, M.A. (Eds.) *Violence in America: A public health approach.* (1991). New York, NY: Oxford University Press.

An assessment of the problem of violence from a public health perspective. Internationally know experts in their fields examine child, spouse, and elder abuse; sexual assault and rape; suicide; assaultive violence; and homicide. Key issues in epidemiology, causal and risk factors, outcomes and interventions are addressed.

Smith, D. (1990). *Caught in the crossfire: A report on gun violence in our nation's schools.* Washington, DC: Center to Prevent Handgun Violence.

This report provides data on the increasing gun violence occuring in and around schools using data collected from 2,500 newspaper stories over four academic years, 1986–1990. Data is provided on the number of incidents, deaths, and woundings by state.

Contact: Center to Prevent Handgun Violence, 1225 Eye Street, N.W., Suite 1100, Washington, DC 20005. Telephone (202) 289-7319. Multiple copies are available at no charge.

U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration. (1986). *Surgeon General's workshop on violence and public health: Report.* Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services.

Proceedings from the October 27–29, 1985 Surgeon General's Workshop on Violence and Public Health. Workgroups produced recommendations in the areas of education, research and services for assault and homicide, child abuse, elder abuse, rape and sexual assault, and spouse abuse.

Contact: NCEMCH Clearinghouse, 8201 Greensboro Drive, Suite 600, McLean, VA 22031. Telephone (703) 821-8955, ext. 254. Single copies are available free of charge.

U.S. Department of Health and Human Services, PHS, CDC. (1991) *Forum on Youth Violence in Minority Communities: Setting the Agenda for Prevention. Summary of the Proceedings.* Atlanta, Georgia: Centers for Disease Control.

Proceedings from a December 1990 meeting of 110 leaders in violence prevention to assist CDC in developing a national strategy for the prevention of violence. Proceedings include data, a review of ongoing violence prevention programs, discussion of future directions and executive summaries of background papers produced for the conference.

Contact: Proceedings available from the Division of Injury Control, CEHIC, Mail Stop F 36, Centers for Disease Control, Atlanta, GA 30333.

Wilson-Brewer, R. and Jacklin, B. (1990). *Violence prevention strategies targeted at the general population of minority youth.* Newton, MA: Education Development Center, Inc.

This background paper was prepared for a Forum on Youth Violence in Minority Communities, and reviewed existing violence prevention interventions. Educational interventions included those to build male self-esteem, conflict resolution and mediation, law-related crime prevention, life skills training, handgun violence education and public education such as videotapes and PSAs. Recreational, environmental techological and legal interventions were also decribed as were potential interventions and some that address other health issues.

Contact: Division of Injury Control, CEHIC, Mail Stop F 36, Centers for Disease Control, Atlanta, GA 30333.

Wilson-Brewer, Renee, Stu Cohen, Lydia O'Donnell, and Irene Goodman. (1991). *Violence Prevention For Young Adolescents: A Survey of the State of the Art.* The Carnegie Council on Adolescent Development.

Presents results from a survey of 51 violence prevention programs around the United States. The paper includes detailed case studies of a select sample of programs, reviews evaluations conducted by these programs, and provides recommendations for advancing the field.

Contact: Carnegie Council on Adolescent Development, 2400 N St., NW, Washington, D.C. 20037-1153, (202) 429-7979. Single copies available free of charge.

Appendix C: Resource List

Children's Safety Network Injury and Violence Prevention Resource Center

National Center for Education in Maternal and Child Health
2000 15th Street North
Suite 701
Arlington, VA 22201-2617
(703) 524-7802
Contact: Laurie Duker, Director

CSN fosters the development and inclusion of injury and violence prevention strategies into maternal and child health services, programs, and organizations.

Technical assistance is available on collection, analysis and application of injury data, preventive interventions, public policy initiatives, coalition building, evaluation and integrating violence prevention into ongoing services. Publications order form available.

Office of Minority Health Resource Center

Office of Minority Health, U.S. Dept. of Health and Human Services
P.O. Box 37337
Washington, D.C. 20013-7337
(800) 444-6472
Contact: Jade Leung, Information Services Coordinator

The OMH-RC maintains information on health-related resources available at the federal, state and local levels that target African Americans, Hispanics/Latinos, Native Americans and other minorities. In addition to serving as a central source of minority health information, the OMH-RC works with the Office of Minority Health to identify information gaps and to stimulate the development of resources where none exist. One of the resource center's priority areas is homicide/suicide/unintentional injury.

CASSP Technical Assistance Center

Georgetown University Child Development Center
3800 Reservoir Road, NW
Washington, DC
(202) 338-1831
Contact: Marva Benjamin

The Child and Adolescent Service System Program's (CASSP) Technical Assistance Center is funded by the National Institute of Mental Health to assist states and communities in their efforts to improve service systems for emotionally disturbed children and adolescents and their families. The center develops and disseminates documents on a variety of topics relating to mental health systems including the development of culturally competent systems of care.

Center to Prevent Handgun Violence

1225 Eye Street, N.W. Suite 1100
Washington, DC 20005
(202) 289-7319
Contact: Vanessa K. Scherzer, Assistant Director of Communications

The Center to Prevent Handgun Violence is a national, nonprofit organization working to prevent handgun violence through education, legal action and research. The center provides data, educational materials and curricula, posters, and information on activities and organizations across the country. An information and publications package is available.

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Appendix D: Participants List

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